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DISSERTATION

Understanding Healthcare Professionals' Identification When Working Within A Stigmatised Organisation

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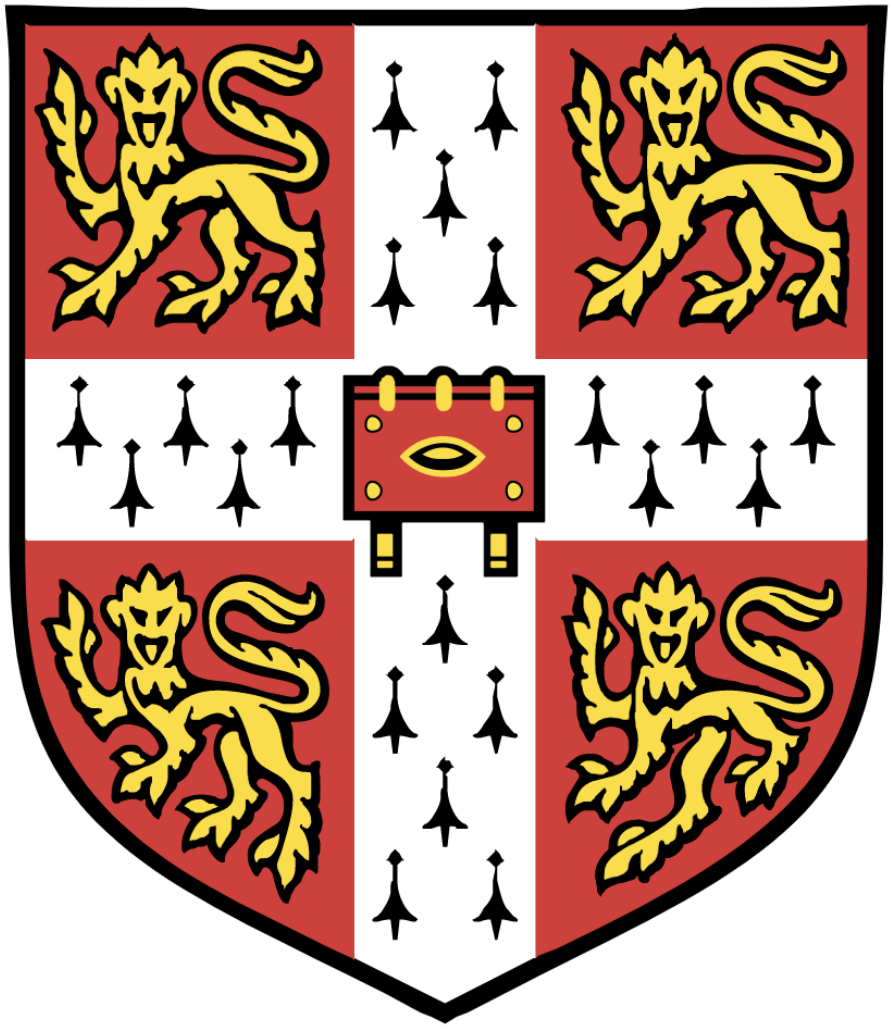

1 ABSTRACT

Organisational stigma is a growing topic of interest for study. There has been a long history of exploring stigma applied towards individuals and more recently how stigma is applied to organisations. Little is known about the effect on employees whose options are restricted to continue working in organisations which have become stigmatised. The process and effect of organisational stigmatisation may present a disruption to the workplace identity of employees who might previously have believed they worked for a prestigious or at least legitimate organisation. Employees may have to construct a new sense of identity within the organisation if they are unable to transfer their employment easily to another organisation. This study examines the effect of organisational stigmatisation on healthcare employees working in an acute NHS hospital. The findings suggest that members of recognised healthcare professions can tactically construct permeable identities to offset the negative evaluations associated with organisational stigma. There is less opportunity for those healthcare employees who are not members of a profession with institutional and regulatory standards to reconstruct identities that can soften the impact of organisational stigma.

1.1 List of Abbreviations

AHP	Allied Health Professional
APOSIE	Acronym of: Active, Passive, Objective, Subjective, Internal, External
CEO	Chief Executive Officer
CQC	Care Quality Commission (independent regulator of health & social care)
ED	Emergency Department
ER	Emergency Room (interchangeable with ED)
HCA	Health Care Assistant (a healthcare worker not in a recognised profession)

NHS	National Health Service
UK	United Kingdom

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3 INTRODUCTION

This dissertation describes a single case study based in an NHS hospital Emergency Department (ED) and explores healthcare professionals' identification when working in a potentially stigmatised organisation. The research focused on two main questions. First how do frontline healthcare ED staff perceive their role when stigma is attached to the organisation? Second how do staff respond when stigma is attached to the individual department or the whole organisation? This study encounters issues on organisational stigma paying attention to the influencing factors of legitimacy and reputation-and in addition explores healthcare professionals' identity and identification- that may in turn have an influence on workforce motivation and commitment in the context of public healthcare values and organisational change.

Stigma is different from the issues of reputation and legitimacy. Interest in stigma has grown as it applies to organisations rather than individuals or communities. This is an important area of investigation since although there is increasing interest in how organisations and their executive corporate boards respond to the threat of stigma or stigmatising events, little is known about how organisational stigma impacts on the frontline workers within a public sector organisation, nor how they subsequently respond both within or outside the organisation.

Adopting the paradigm of interpretivism, based on the way people behave being intertwined within the social context, this research considers the intersection between organisational stigma and individual agency to effect organisational change. This is also an important area to study since regulatory and reporting bodies with significant influence construct the frame through which public organisations are viewed. It is commonly claimed that true transformational

change can be achieved "bottom up" and in the case of healthcare from those employees closest to the patients. Through this lens insights may be gained on where to focus efforts, approaches and resources directed at healthcare employees to achieve greater value to society in the broader context of emergency and urgent care. This study also attempts to understand if the threat of organisational stigma influences how a department and professionals perceive themselves and how they respond in such circumstances to negotiate and navigate changes within the organisation.

3.1 Background to the Index Case

Hospitals are a major symbol of the civic structure and values of society. The Emergency Department is highly representative of the purpose and societal value of a hospital. As organisational stigma markers are often attached to part but not all of an organisation, organisational members may be able isolate and remove cleanly the stigmatised parts of the organisation while preserving the legitimacy of the remainder of the organisation (Paetzold et al., 2008). Some hospitals in the UK have merged or closed down resources and chosen to embed emergency services in one hospital rather than another. This indicates it is possible in some circumstances to separate an emergency department from its parent hospital.

The Emergency Department in the index hospital is an unusual although not unique NHS entity. The hospital is a supra-regional major trauma centre and also serves the emergency needs of the local population. The Emergency Department is *integral* to and *inseparable* from the index hospital. The co-dependency has been described in the following way: "When ED sneezes the hospital catches a cold and *vice versa*" (anonymised source – personal communication). It is this inseparable co-dependency, the transferability of stigma and

healthcare professionals' attempts to manage their identity towards states of legitimacy and prestige when faced with stigmatising events that form the basis for this study.

4 LITERATURE REVIEW

In this review of the literature the focus is on organisational stigma, although an appreciation of individual stigma is useful in understanding the origins of stigma. Qualities typically applied to a person can be converted by society to anthropomorphise an organisation, in turn permitting the attachment of labels evaluating and describing conduct and character. Stigma is distinguished from simply being a consequence of negative perceptions of reputation and legitimacy, but these latter two concepts are worthy of inclusion in the literature review since they are both social constructs that ultimately can influence the evolution of stigma being applied to an organisation. The literature review will subsequently briefly outline organisational motivation, identity, identification and commitment since these are elements of frontline workers' activities or beliefs that can be perceived as markers of individual and collective agency while employed in a professional role within an organisation.

4.1 Overview of Organisational Stigma, Reputation and Legitimacy

Organisational Stigma

Deviation from legitimacy and an adverse reputation can sow the seeds for stigma. Acknowledging the origins of legitimacy and reputation informs how erosion of these attributes promotes stigma. Stigmatisation is the social process by which a person with an attribute viewed as offending is denigrated. A theoretical basis for organisational stigma is labelling

theory grounded in the sociology of deviance. Individuals transform into deviants on the responses of the conventional and conforming members of the society.

The landmark scholarly work on stigma is from Goffman in which stigma is described as "an attribute that is deeply discrediting" (Goffman, 1963). More recently stigma can be assessed in relation to organisations using this definition: "organisational stigma is a label that evokes a stakeholder group-specific perception that an organisation possesses a fundamental deep-seated flaw that deindividuates and discredits the organisation" (Devers et al., 2009). A stigmatised organisation is emblematic of the negatively evaluated category to which the organisation is linked and hence the stigmatised organisation becomes caricatured as an embodiment of the values that conflict with the values of the stakeholder group. Hence it is the stakeholders that "disidentify" from the organisation (*ibid).* One can examine the effects of stigmatisation and stakeholder dis-identification (Elsbach and Bhattacharya, 2001). Goffman (1963) advised the need for a language of relationships not attributes. Stigma may focus on the subject of the labels society attaches, while discrimination focuses on those who create and attach the label.

The process of stigmatisation is contingent on a relation in which the labellers have more social, economic and political power than the stigmatised persons. This becomes more complex and multifaceted when applied to organisations. For stigmatisation to occur, a critical mass of negative evaluations has to exist (Abrahamson and Fombrun, 1994). Labelling in stigmatisation must diffuse across an influencing body of members in a stakeholder group. This is the tipping point between stigmatisation and non-stigmatisation (Grodzins, 1958).

The strength of stigma experienced by an organisation depends on several factors: first the distance or gap between the values of the stakeholders and the core values of the organisation being evaluated; second the stakeholders' awareness of the organisation's core values and third the size, power and influence of the stakeholders with capacity for attributing stigma (Hudson, 2008). Power dynamics may influence stakeholder organisation participation in the labelling and stigmatised interaction (Devers et al., 2009) .

Core stigma is due to the nature of the organisation's core attributes – what it is, what it does and whom it serves (Hudson, 2008). Core stigmatised organisations cannot achieve broad based support i.e. legitimacy (Vergne, 2012). Event stigma looks at consequences arising from some negative event (Neu and Wright, 1992; Sutton and Callahan, 1987). By this definition most hospitals and healthcare settings should not be core stigmatised. However, all healthcare organisations may be vulnerable to event stigma by social perception at some point in time. When social audiences withdraw their social support for the organisation, the organisation risks becoming stigmatised. Therefore organisational stigma is a social phenomenon that may involve collective perceptions of members of a particular group.

Stigma is not necessarily the same thing as a poor reputation. The formation of organisation reputation is explored by Ravasi demonstrating areas of overlap between the construct of reputation and the construction of stigma in particular from stakeholders external to the organisation (Ravasi et al., 2018). Stigmatisation of organisations can be the result of contested definitions depending on the views and role of external stakeholders, and that which may be acceptable to one group may appear unethical to another. This may be relevant to employees within the organisation who can feel detached from the concept of a stigmatised organisation (Hudson and Okhuysen, 2014).

Organisation stigma focuses on *conduct* of the organisation while individual stigma more easily relates to *identity* and conforming to normative expectations. Organisational stigma can be at its greatest when directed at an organisation's conduct *and* identity (Law, 2016). Assessments of capability and character are different but together they can construct both positive and negative aspects of an organisation's reputation (Mishina et al., 2012).

Investigating organisational stigma draws together an interdisciplinary field of research and opens the possibility to investigate the subject through many lenses and theories since it is a product of social perception. Identity theory, power theory, game theory and labelling theory grounded in the sociology of deviance are all examples of potential foundation theories for research on organisational stigma (Link and Phelan, 2001; Devers et al., 2009).

The implications of power theory applied to healthcare settings are important since regulators and politics highlight the social, legal and economic arbiters that can influence the degree of stigma to which an organisation is subjected. These three arbiters are highly interrelated and interact in an iterative way to maintain the trust of stakeholders and the public (Wiesenfeld et al., 2008). Stigmatisation of an organisation may help maintain organisational ideals within society, a legal influence may set the standard of deviance to be avoided by others, and economically, limited resources can be directed to other organisations with their legitimacy intact, ensuring the long-term survival of socially acceptable organisations.

Whetten and Mackey (2012) defined an organisation as "a social aggregate authorised to engage in social intercourse as a collective and possessing rights and responsibilities as if the collective were a single individual" (Foreman et al., 2012). Individuals have a tendency to anthropomorphise non-human agents and objects (Epley et al., 2007) and this can be extended

to include organisations (Love and Kraatz, 2009). Hence judgement biases normally applied to individuals can be applied to organisations. Organisational identity may be characterised by the cultural stage upon which organisational activity is played out (Pruzan, 2001). Organisational identity is highly situational. Thus organisations may have a unique social status invested with the same rights and responsibilities as individuals. This definition permits organisations to be held accountable for the decisions they make (King et al., 2010). Organisations are complex entities and it is possible to have stigma applied to only part of an organisation. Hence it is possible to isolate and distance the rest of the organisation from that stigmatised element (Paetzold et al., 2008). Organisations have greater opportunities at their disposal compared to individuals to prevent or remove stigmas. Organisations made up of multiple components potentially can manage stigma by redrawing the boundaries to exclude the offending part or member (Devers et al., 2009). If they eliminate the main source of stigma they become a different type of organisation. Hence for the *original* organisation to survive it has to find ways of contravening the source of stigma. In the context of this research the organisation cannot (and neither would want to) remove or disown the Emergency Department from the very core of the hospital in terms of its essential activities and responsibilities of an acute NHS Trust.

Hospital reputations in the UK are in part dependent upon their ranking according to stipulated criteria from the Department of Health. Emergency Department "performance" is frequently reported in government presentations and the general media with hospital trusts placed in a rank order. Appearing in a rank provides a signal of quality to stakeholders that will eventually benefit the receiving organisation. However it is not only the direction or placement in the rankings but also the consistency of placement that will influence the interest of stakeholders

(Moos et al., 2018). Hence organisational reputation as well as legitimacy needs to be taken into consideration when attempting to understand the origins of organisational stigma.

Organisational Reputation

Organisational reputation can be defined as: "the collective, stakeholder group-specific assessment regarding an organisation's capability to create value based on its characteristics and qualities" (Rindova et al., 2005). The formation of reputation is complex. Ravesi *et.al.* (2018) describe six perspectives on the formation of reputation: game theoretic, strategic, macro-cognitive, micro-cognitive, cultural-sociological and communicative. Macro-cognitive, cultural-sociological and communicative perspectives focus on the formation of reputation in complex environments with heterogenous actors, interests and roles.

The game theory perspective examines the influence of reputation on repeated competitive interactions. The strategic perspective considers reputation as an intangible asset and how organisations signal their intentions, purpose or response to events. A third perspective, the macro-cognitive perspective, considers an aggregate of diverse perceptions and cognition by a variety of stakeholder groups. It highlights prominence of the organisation and the general favourability of the evaluations. It may be reflected as reputational rankings. It also focuses on the formation of reputation through *social construction* In contrast, the micro-cognitive perspective assesses how individuals access and process information to form reputational judgements of organisations and how they differ in doing so. It looks at multi-dimensional individual judgement and information processing. Most research in this field recognises that reputational judgements are made with incomplete information, bounded rationality, reliance on heuristics and mental shortcuts as well as cultural biases. It looks at how individuals selectively attend to different information and process it differently. A fifth perspective, the

cultural-sociological perspective, focuses on how reputations are constructed in the public domain. It highlights the discursive and socio-political process of organisational reputation evolution. It can help to draw attention to the distortions and biases in the evolution of reputation. Finally the communicative perspective considers organisational identity and positioning, and the influence this has on stakeholders. Reputation is a communicative construction with continuous re-evaluation and is influenced by communicative interactions (Ravasi et al., 2018).

These six perspectives may be combined to avoid blind spots and unilateral assessment of influencing factors, and combining them helps to develop a sophisticated understanding of three paired but countervailing issues of reputation formation: First ‘stability and change’ - these have both internal and external forces; second ‘control and contestation’ relating to organisational control and external influence, and third ‘micro and macro’ levels of analysis, highlighting the social construction of reputation.

These perspectives converge to provide an understanding of reputation as an evaluative and comparative representation of an organisation. This in turn influences stakeholders’ understanding and behaviour. It follows that reputations are collectively held judgements. Reputation begets reputation (Rao, 1994). Reputations may be subjective rather than objective measures (Sehgal, 2010). In the absence of perfect information, stakeholders use reputation as a proxy in order to make decisions (Mishina et al., 2012). Stakeholders make assumptions about how an organisation should behave based on its membership and self-definitions. This in turn will determine the standards which are to be expected and by which the organisation will be judged. Accountability standards define how an organisation *should* behave. Stakeholders use institutionalised standards to assess and compare organisations.

Institutionalised standards form the components of legitimacy for organisations. Society 'benchmarks' organisations against others with reference to those practices that are deemed to be legitimate or illegitimate. This is a binary and apparently absolute process for comparing organisations, but again, legitimacy is socially constructed, and legitimacy may be multifaceted. It would seem natural for all organisations to desire to be perceived as legitimate in their conduct.

Organisational Legitimacy

Legitimacy may be defined as: "A generalised perception or assumption that the actions of an entity are desirable, proper or appropriate within some socially constructed system or norms, values, beliefs and definitions" (Suchman, 1995). Legitimacy is a property of an institutionalised social category or social form that is conferred on its members or adopters. Both legitimacy and reputation are components of many organisations' social identity. The *standards* and relative *standing* are socially constructed. There is a dual identity requirement (King and Whetten, 2008).

The need to legitimate the administrative state may be motivated by the suspicion that it is not actually legitimate (Spicer and Terry, 1993). This concept may be extended to public sector bodies in general. Organisational legitimacy may reflect worth and affection from the general public (Rohr, 1985). Lack of legitimacy has negative consequences for organisations, its workers and outside partners (Hudson and Wong-MingJi, 2001; Hudson and Okhuysen, 2008).

In complex situations society relies on a selected set of arbiters (intermediary or approved sense-makers) to render and disseminate judgements (Hirsch, 1972; Zuckerman, 2000). Theories of socially situated judgement describe a process of constituent minded sensemaking

(Bell and Tetlock, 1989; Kahneman, 2003; Tetlock, 2002). Key intermediaries or "arbiters" act within the social and psychological context of their interactions. These arbiters typically have legitimate platforms to make assessments of individuals' values and subdivide into social, legal and economic arbiters. Examples of social arbiters include the press, governance watchdogs, academics and special interest activists. Legal arbiters include regulatory officials and the judiciary. Social and legal arbiters involved in the stigmatisation process become an important audience for economic arbiters. Economic arbiters may be other members of a business elite, peer group or grant making body. In the process of avoiding stigma, organisations must convey signs of legitimacy and normalcy to maintain favourable terms with their constituents and arbiters (DiMaggio and Powell, 1983).

Stigma exists when the following five interrelated components converge: First, people distinguish and label human differences. Second, dominant cultural beliefs link labelled persons to undesirable characteristics. Third, labelled persons are placed into distinct categories creating "us and them". Fourth, labelled persons experience status loss and discrimination that leads to unequal outcomes. Fifth, and finally, stigmatisation is entirely contingent on access to social, economic and political power that allows the identification of differentness, the construction of stereotypes, the separation of labelled persons into distinct categories and the full execution of disapproval, rejection, exclusion and discrimination (Link and Phelan, 2001).

Organisational responses to stigma may be strategic, structural or network related. One strategy of interest is the choice of an organisation to claim "specialist" status and to differentiate itself from more generalist organisations. Other strategies include "hiding" or lowering the profile of the organisation which is being compared, "challenge" and overt fighting back approaches

and zero tolerance to legal infringements to dissuade others from joining in on the stigmatising process. These strategies focus on changing organisational image and organisational identity.

Organisational image is the perception that insiders wish to portray or project to outsiders. Image is internally derived and therefore may be contested by external stakeholders or audiences who may introduce stigmatisation. Organisational identity is the perception of insiders of what is central, enduring and distinct about an organisation (Albert and Whetten, 1985). This is contrary to core stigma which is an evaluation made by outsiders. This research proposes that how key frontline workers perceive themselves and their role is critical to managing the threat and consequences of organisational stigma. Section 4.2 goes on to examine organisational identity, the process of identification and to then describe elements that may be of significance to how workers engage with their employing organisation, namely through issues of motivation and commitment that ultimately help them to construct an identity of relevance to the organisation.

4.2 Identity, Identification, Motivation and Commitment.

Organisational identity consists of the beliefs about central enduring and distinctive characteristics of the organisation consensually held by organisational participants (Weick, 1995). Affiliation to an organisation can be a motivational driver. Employee motivation is inversely proportional to the size of the organisation or company (Li Sun and Fuschi, 2015). This may be of relevance in the context of this research where the index hospital as a whole has over 8000 employees though the part of the organisation to be studied – the Emergency Department- has a few hundred employees in total.

Social Identity Theory states: “a social category in which one falls, and in which one feels belongingness to, imports defining characteristics on the actual category, in turn becoming part of one’s self-concept”. Social Identity Theory can be incorporated into an understanding of organisational identity (Ashforth and Mael, 1989). Social identity theory has been studied in relation to front-line employees. Employees’ identification is relevant to an understanding of their work performance, and the reciprocal understanding of the organisation’s performance influences their identification with the organisation (Carmeli et al., 2007). This indicates an intimately linked oscillating process of intra-organisational identification. Additionally, employee perceptions of how external stakeholders experience the organisation’s demeanour can in turn influence employee behaviour toward their own organisation. There can be a reciprocating influence since front-line employees as the “face” of the organisation shape stakeholder perceptions of the organisation (Schaarschmidt et al., 2015).

Identity is a highly social and truly individual matter. One’s identity consists of references to groups whose opinions matter to the individual. Identity is a feature of organisations, but differences exist between the features of the organisation and the individual. Identity is constantly being produced, reproduced and altered via external presentations of identity. Multiple identities can be held by one individual professional at any one time. Different identities may be loosely coupled in that a change in one does not necessarily effect a change in another (Mael and Ashforth, 1992). An identity may not be recognised or revealed until ‘activated’ in a certain situation. People have dimensions of themselves that get used to various degrees in engaging and disengaging at work (Kahn, 1990). Many aspects of identity may be institutionalised.

In accordance with Social Identity Theory, an individual's social identity is enhanced when the group to which he or she belongs is distinctive and more favourable than comparable groups (Ashforth and Mael, 1989; Carmeli et al., 2007). Professional identity is different from professionalism. Professionally identified employees may choose actions based on professional rather than their employers' preferences (Tompkins and Cheney, 1985).

Identification is the process of emerging identity. It represents the forging, maintenance and alteration of links between persons and groups. Identification is participative and dynamic. Identification is a communication based variable that refers to a person's attachment to reference groups such as organisations occupations and work terms (Apker et al., 2003). *Organisational identification* is developed: "when one integrates beliefs about one's organisation into one's identity" (Pratt, 1998). Organisational identification has affective and behavioural components. Identification in one role may not be relevant in another role (Tompkins and Cheney, 1985). Identity and identification may be situational. Identity and identification make sense of one another and are products of one another. Identification may change when the collective's identity is challenged (Cheney and Tompkins, 1987). *Organisational Identification* is a process of cognitive self-definition (Dutton et al., 1994). "Identifications… aid us in making sense of our experience, in organising our thoughts, in achieving decisions and in anchoring the self. Identifying allows people to persuade and be persuaded" (Cheney, 1983).

Work motivation is defined as the willingness to exert high levels of effort towards organisational goals, conditioned by the individuals ability to satisfy some need (Mafini and Dlodlo, 2014). This definition has its origins in the motivation work of Herzberg which distinguishes intrinsic motivators such as recognition, responsibility and autonomy from

extrinsic motivating factors such as remuneration, working conditions and prestige referred to as hygiene factors (Herzberg and Mausner, 1959). In relation to Maslow's hierarchy of needs (Maslow, 1943), the higher needs of "belongingness, esteem and self-actualisation" may be adversely influenced by organisational stigma. Porter outlined a broad theory of motivation with several elements that can be drawn upon (Porter et al., 1975). The emotional attachment an employee has with his or her job may in turn influence his or her work motivation (Saari and Judge, 2004). Employee motivation is a vital ingredient for achievement of organisational goals and objectives (Badubi, 2017).

Commitment may be defined as a force that binds an individual to a course of action that is of relevance to a particular target (Meyer and Herscovitch, 2001). "Commitment develops as a result of experiences that satisfy employees' needs and/or are compatible with their values" (Meyer and Allen, 1991). Three elements comprising attitude, behaviour and affect influence employees' organisational commitment.

Negative social evaluation of organisations and institutions is a growing topic of interest. Stigma is a particular form of negative social evaluation and illustrates the use of power in reforming reputations and legitimacy when there is an imbalance of power. Lifting the covers on a stigmatised organisation and exploring the impact on individuals or groups of employees through the language of motivation, identification and commitment provides insights into the insidious and pernicious effect of stigma.

4.3 Identifying the Knowledge Gap in the Literature and Field of Study

Why study Organisational Stigma and the Impact on Employee Identity?

Stigmatisation has a bearing on the distribution of life chances. It follows that social scientists who are interested in the distribution of such life chances should be interested in stigma. Understanding issues of organisational stigma contribute to an understanding of how society in the United Kingdom is structured.

This research is unique since it explores an example of an inseparable entity, core to an organisation linking integral co-dependency with mutually interchangeable elements of stigma and prestige. The research advances an understanding of the interplay between perceived organisational stigma and the identification and motivation of employees to effect changes that influence the employees' identity, legitimacy and reputation among multiple stakeholders.

Professional identity is distinctive among the sorts of identity experienced at work because of its extra-organisational character. It is multi-level involving individual, organisation and institution. Professional identity implicates multiple levels of analysis. Identities are context bound. This has been described succinctly by Caza and Creary. The variation of professional identity constructs at the organisational and individual level should indicate the degree to which they are influenced by organisational context (Barker Caza and Creary, 2016). Studying a healthcare organisation provides insights into a public resource with a highly regulated and professionally institutionalised workforce.

Stigma when applied to organisations such as public hospitals can occur at a macro level such as whole system financial mismanagement, poor and unsafe maintenance of the estate or large-scale losses of data. In contrast, stigma may occur at the micro level and become attached to a

single element of the organisation or even a single individual The organisational stigma may oscillate between macro and micro status through a convergence of beliefs and actions of multiple stakeholders both external and internal to the organisation.

Courtesy stigma or stigma by association (Goffman, 1963) is not triggered by qualities or behaviours of an individual but can occur simply because observers have made the association. Members of a stigmatised group may be protected by organisational policies or regulations but employees stigmatised by association may have little recourse (Kulik et al., 2008). Stigmatisation creates divided loyalties within organisations and the stigmatisation process external to an organisation may be echoed internally (Tracey and Phillips, 2016).

A need to study stigma, public healthcare organisations and resource allocation

For stigmatisation to occur power must be exercised. Studying organisational stigma alerts us to the ways power is used. A focus on stigmatisation can reveal the power disparities between the stigmatised and the stigmatising. It allows one to observe forms and uses of power (Lawrence, 2008). Those with power are able to label, name and define what is normal and thus to determine status, access to resources and outcomes (Hardy and Phillips, 1998).

Stigma is a phenomenon that demonstrates the contested nature of organisational activities. Stigma alerts us to locations within organisations where there are competing institutional pressures. Contestation in the form of stigmatisation is created by the presence of multiple stakeholders who are embedded in multiple institutional configurations. Studying stigmatised organisations focuses attention and reflects interest on the role of those stakeholders who contribute to the construction of stigmatisation. Knowledge and the unveiling of organisational stigma in healthcare may demonstrate how resources are allocated, consumed and regulated.

Examining stigmatised organisations can reveal how organisations function in the absence of legitimacy or with negative reputations. An analysis of stigma applied to an organisation may subsequently help the organisation to establish a new and more valued identity (Paetzold et al., 2008).

Moura and Miller (2016) argued that public sector organisations deserve to be core stigmatised. This may be a way of using power to keep the public sector accountable and to drive standards for enforcing reform. Core stigma is a type of stigma that cannot be eliminated and hence should be embraced for what it is and managed within the context of its very presence (Moura and Miller, 2016). Contentiously, the NHS may or may not be core stigmatised from covert ideological political and financial perspectives but event stigma involving different organisations and individuals is often the subject of open discussion.

Stigmatisation is the result of contested definitions and what may be unacceptable to one group may remain perfectly reasonable to another. The Emergency Department four-hour target to completed treatment or admission in UK hospitals may be viewed in this way, where clinical staff value treating patients in order of need and clinical urgency rather than order of arrival in the department. Targets are the cornerstone of the rating system for assessing performance of hospitals in the UK. The stakes for not meeting them are very high and if missed can significantly affect hospitals' reputations and future funding (Mayhew and Smith, 2008). Appreciating how stigma applied to an organisation might influence motivation may influence the conceptualisation of value in healthcare and challenge the application of targets to achieve healthcare reform.

Research into stigma is often from a vantage point uninformed by the lived experience of the people they study (Kleinman et al., 1995; Schneidre, 1988). Studying organisational stigma through the critically situated lens of the participants - in this case Emergency Department practitioners - opens up new understandings of the process and effects of organisational stigma. The study explores the impact of organisational stigma on individuals and small teams of employees of mixed professional and non-professional status revealing tactics of resistance, avoidance or acquiescence to the imposed label of stigma.

The study provides insights into the challenges relating to organisational identity of acute hospital trusts in the United Kingdom that have an Emergency Department as the "face" or "front door" of the organisation. The research has potential implications for employees and management teams in acute hospitals, as well as the regulatory stakeholders that establish and review standards for care in the United Kingdom.

5 RESEARCH METHODS

The methodology adopted was based ontologically and epistemologically in a subjectivist perspective reflecting the nature of the data sources as well as my own experience and understanding of the context of acute hospital emergency activity. Overall it was weighted towards an inductive approach designed to generate new theory from which other research could be undertaken. The inductive design of the research followed the Gioia methodology with collection of data in a flexible design, in part iterative to progress through first and second order analysis to produce a data structure and themes that could build toward a model or theory (Gioia et al., 2013).

An initial literature review focused on concepts and definitions of legitimacy, reputation and organisational stigma. In addition, literature on identity, identification, motivation and commitment was reviewed. Examining concepts between the two fields of organisation stigma and identification in organisations revealed a gap in the literature relating to how healthcare professionals integral to and inseparable from an organisation that is stigmatised navigate and make sense of their working existence. Data were explored to expose attitudes and beliefs of the contributing individuals. A longitudinal element to the study data set was sought from available staff survey data. The surveys also provided a lens through which to view additional data revealed through a "listening event" and data captured from humorous transcripts of a musical revue helping to identify and construct themes.

Ethical approval to undertake the research was obtained from the University of Cambridge. Organisational approval was granted to gain access to mandatory NHS National Staff Survey data and to approach participants in a "listening" event. Anonymity was guaranteed to promote free discussion and I ensured no comment could be attributed to a specific individual. No information relating to individual patients was recorded although professional roles were recorded except where a role was unique or where there were less than 10 members of staff in that role. The setting for the case study is an Emergency Department within an acute NHS Trust subsequently referred to as "the index hospital". Its' doors are always open, it is essential, core and integral to the hospital. It both performs and symbolises a significant element of acute healthcare and justification for the economic, political and social purpose of the organisation.

The context for the index case study

In May 2014, after seven years of planning and four years of construction, two NHS hospital sites that were part of the same NHS Trust moved into a newly built £430 million hospital with much publicity as the old hospital sites were decommissioned. The move involved an instant

blending of hospital cultures and legacies. Within a few months the Care Quality Commission (CQC), the independent regulator of health and social care in England inspected the hospital and its services and rated it overall to "require improvement" In particular, the CQC rated the Emergency Department (ED) as *"inadequate"*, the lowest possible rating (other ratings being "requires improvement", "good" and "outstanding"). The CQC publicly announced findings and undertook to return to measure and assess improvements. When the CQC revisited in 2015 the Emergency Department was again rated *"inadequate"*. Shortly afterwards the Hospital Trust announced a projected significant financial deficit, a Turnaround Director was appointed, and the hospital was placed in Financial Special Measures, arguably a humiliating and morale-sapping experience. The hospital persistently had some of the longest patient waiting times in England, typically in the bottom 10 out of 166 Acute Hospital Trusts and frequently in the bottom five. (Waiting times were judged by the percentage of patients breaching the Government target of four hours). Significant effort and resource were placed on improving patient "flow" through the hospital in the belief that getting patients out of the "back door" of the hospital eased and facilitated the transit of patients coming through the "front door" – the Emergency Department. The winters of 2016 and 2017 saw large numbers of patients queuing in corridors and makeshift bed spaces, again with adverse publicity. Finally, in the summer of 2018, the hospital had plenty of available inpatient beds, but the Emergency Department was unable to treat large numbers of patients within the four-hour target. At this point there were unsubstantiated rumours that the Emergency Department was fundamentally flawed in its conduct, competency and capability. The Emergency Department had potentially become stigmatised within the context of an already stigmatised organisation.

Sources of data

This study relies on three sources of data: First NHS National Staff Survey data with a granularity of data to permit analysis of different staff groups (although not to the level of identifiable individuals). Second, analysis of a "listening event" capturing the written comments reflecting proposals and beliefs of frontline emergency department staff. Third, direct observation and analysis of a revue* written and performed by staff from the Emergency Department. In order to try and obtain the "frontline, ground-up" perspective Data from staff in a range of roles and backgrounds was examined e.g. Receptionists, Healthcare Assistants, Nurses, Consultants, Allied Health Professionals. Data was deliberately not sourced from staff who were in training since they would only be passing through the department transiently. The participants contributing to the data set came from a variety of economic, educational and cultural backgrounds and this approach helped with a maximum variation case sampling methodology within subgroups. This study was very much qualitative research. The "listening event" provided an open opportunity to explore and to understand the collective beliefs and attitudes of a department. The NHS National Staff Survey data provided the potential to stratify responses by professional role, employment experience and more general demographic information. In contrast, the assessment and analysis of transcripts of a humorous musical revue was undertaken with less transparency with contemporaneous handwritten notes being made during the performance and subsequent analysis of the transcripts of the text and libretto. This approach provided a degree of methodological eclecticism and contributed to triangulation of data sources to analyse for themes.

* [A revue is light theatrical entertainment consisting of a series of short sketches, songs and dances, typically dealing satirically with topical issues. The revue art form brings these elements together to create a compelling show (*Revue*, 2019)]

6 DATA COLLECTION AND ANALYSIS

6.1 Collection of Data

The index hospital trust submitted its 2017 and 2018 National Staff Survey data to a provider of data analytics that could provide a very granular presentation of data to specific data controllers at contributing hospitals, but this level of data is not in the public domain. Permission was gained for an analysis of the NHS National Staff Survey for 2017 and 2018 specifically relating to employees of the Emergency Department of the index hospital. Comparison of 2017 and 2018 data permitted a longitudinal data assessment to be applied to the research. Comparisons of an organisation over time is a valuable measure of progress (Saari and Judge, 2004).

A "listening event" was arranged by the index trust to hear the concerns, ideas and views of frontline staff working in the Emergency Department. My role in the event was not to extract information actively from staff nor to construct plans for acting on the suggestions, but simply to observe the process and subsequently analyse the responses for themes. I chose to analyse the data in terms of the beliefs of the participants and the tone of the responses.

A third source of data was obtained from observing and actively listening to a humorous revue written and performed by staff from the Emergency Department. Contemporaneous notes were taken, and the transcript was analysed later for evidence of additional or common themes emerging from the listening event or staff survey. The musical revue *"Mama E.R."* was widely advertised within the local healthcare community with invitations for non-emergency

department workers extending right up to the CEO to attend. This provided another opportunity for the voices of the "frontline" to be heard.

6.2 Analysis, categorising & coding of data

Summary demographic data and findings from the 2017 and 2018 ED specific staff survey:

The NHS National Staff Survey covers six domains asking employees questions relating to "Your Job, Your Manager, Health, Safety and Wellbeing at Work, Personal Development, Your Organisation and Background Demographics".

The 2017 and 2018 index hospital staff surveys were reviewed at points with similar domains that would permit a comparative analysis. There were no demographic differences between 2017 & 2018 for the Emergency Department staff of the index hospital.

140 staff members participated in 2017 representing 49% of the ED workforce.

112 staff members participated in 2018 representing 39% of the ED workforce

Five distinct occupational groups could be identified:

1. Clerical and Administrative
2. Consultants (α, β)
3. Health Care Assistants (HCAs)
4. Sisters and Charge Nurses (α, β)
5. Staff Nurses (β)

[α indicates senior clinical staff in the department, β indicated professional membership and accountability to the following professional governing bodies: the General Medical Council or the Nursing and Midwifery Council]

Responses from these groups were looked at for evidence of negative views of the organisation, commitment to work, feelings regarding personal development and relationship with managers. Responses contributed to elements of the subsequent 39 first order themes.

In both the 2017 and 2018 cohorts, almost 70% of staff had been working in the department for two or more years and this number included 50% of staff who had worked in the department for more than five years. Thus the majority of respondents would have experienced some if not all of the negative events to have befallen the index hospital from the day it opened its doors.

Across both 2017 and 2018 negative opinions about the organisation were always in a minority although not in insignificant numbers, with one solitary exception in 2017 when 54% of Sisters and Charge Nurses did not feel that they received any regular feedback from the organisation.

In 2018 the staff group consistently with the least favourable views about the organisation were the Health Care Assistants. This contrasted with 2017 where there was a wider distribution of staff groups with negative perceptions of the organisation although the most affected group were the Sisters and Charge Nurses, followed by Clerical Staff. In all domains from 8a to 9d of the staff survey Clerical Staff felt the largest disconnect from senior managers.

All staff groups showed high levels of commitment to coming to work even in less than ideal circumstances such as poor health. All staff groups committed extra paid time and effort toward the organisation indicating a potential financial motivation, although for possibly different socially oriented goals given the differential earning capacity between Consultants and HCAs for undertaking additional shifts. The greatest commitment to unpaid additional work most notably came from the Consultants and Sisters or Charge Nurses, i.e. the senior clinical

members of the department with accountability to professional governing bodies, leadership roles within the index trust and the department as well as membership or affiliation to Royal Colleges. Representative tables of data are in Appendix 2 page 65**.**

Summary Results from Frontline Emergency Department staff feedback

Staff in the index hospital emergency department were offered the opportunity to attend "drop-in" or "listening" sessions to provide commentary and ideas relating to three lines of questions: First "What do we need to stop doing?" Second, "What do we need to start doing?" Third, "What do we need to carry on doing?"

Staff attended over a nine-day period from a Monday to the following Thursday to ensure weekend workers had an opportunity to contribute. Variation in timings of drop-in sessions allowed staff working different shift patterns to participate. Although no night shift sessions were undertaken, the sessions at 07:00 and 07:30 had the potential to catch night shift workers at the end of their shift. A total of 41 members of the ED staff attended the drop-in sessions representing 14% of the index hospital emergency department workforce.

Staff hand wrote their ideas or comments on several A0 size flip charts along the three themes of "Carry On Doing", "Stop Doing" and "Start doing". The staff contributions mapped to five broad themes: Pathways (or "the way we do things around here"), behaviours focusing on staff interactions, capacity within the department to meet the needs of patients or to deliver expected standards of care, demand on physical and human resources. These latter three all mapped to an additional theme of overcrowding and 'pressure' within the emergency department. The volume of responses revealed a strong desire for staff to change their working practices and

work environment demonstrated by the 1:5 ratio of “carrying on” to “change” (stop/start doing).

The *“listening event”* data from the initial five broad themes was then assessed for themes of content and context. The tone or “voice” of the participants were assessed, and linked themes were put into emerging categories. Each contributing comment regardless of category was assigned one of six codes in three paired but opposing valences. These were **A**ctive/**P**assive; **O**bjective/**S**ubjective; **I**nternally directed/**E**xternally directed. Valences were either +1 or -1 for each of the paired codes. This generated an **APOSIE** score for each comment and an associated net valency. Valences were assigned a yellow (positive) or red (negative) face. The spectrum of scores was used to identify second order themes.

APOSIE is a bespoke scale that I developed in an attempt to provide a consistent approach to assessing the tone of the language pertaining to subjective statements and beliefs. It has not been used in other contexts and has not been validated. However the use of ‘faces’ in assessment scales has an established history and can be quite sensitive, e.g. the General Measure ‘Faces’ scale that has five faces from smiling to sad which best describe overall satisfaction (Kunin, 1955). In addition assigning a valency adopts a ‘sum of facets’ approach to scoring that has been used in the two most extensively validated employee attitude surveys, the Job Descriptive Index (Smith, 1969) and the Minnesota Satisfaction Questionnaire (Weiss et al., 1967). APOSIE with valences permitted analysis of subjective statements using both a nominal scale with three paired dichotomous elements as well as being able to create an ordinal ranking with cumulative net valences that revealed a hierarchy of values.

Summary Results from "Mama ER" - the Revue

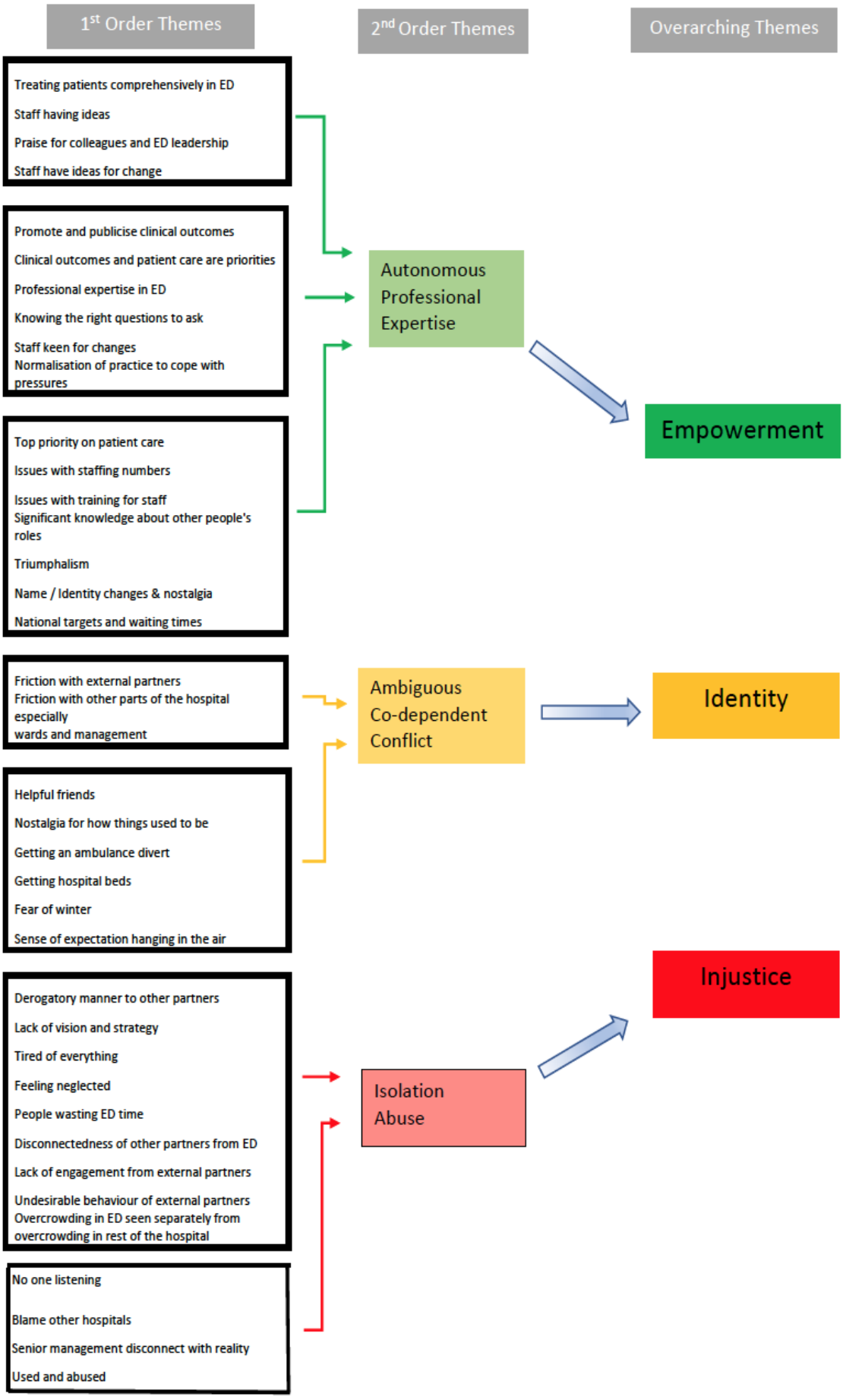
Healthcare professional groups featuring internal staff with positive themes reflecting competence, expert knowledge and skills included: ED Consultants, Radiographers and the Rapid Emergency Assessment and Care Team (REACT). Less complimentary themes were directed externally at Orthopaedic surgeons, Psychiatrists, General Practitioners, Ambulance Control Centres and neighbouring emergency departments. Internal department reflections tended to be focused on themes of "knowing the job", "helpful friends" and "heroic triumphalism". Reflections external to the department had an overriding theme that others were "less than helpful" and were deserving of blame and ridicule.

(Examples of songs are in Appendix 3, page 68)

The **APOSIE** process was repeated for the "*Mama E.R."* revue and iteratively assessed with "*listening event"* data to refine the first and second order themes assisting in the development of overarching themes.

6.3 First Order, Second Order and Overarching themes

Ultimately, 39 first order themes were identified that mapped to seven second order themes which could be refined into three overarching themes. These are illustrated in the following chart and in more detail in Appendix 4b, page 72.


1st Order Themes
2nd Order Themes
Overarching Themes
Treating patients comprehensively in ED
Staff having ideas
Praise for colleagues and ED leadership
Staff have ideas for change
Promote and publicise clinical outcomes
Clinical outcomes and patient care are priorities
Professional expertise in ED
Knowing the right questions to ask
Staff keen for changes
Normalisation of practice to cope with pressures
Autonomous Professional Expertise
Empowerment
Top priority on patient care
Issues with staffing numbers
Issues with training for staff
Significant knowledge about other people's roles
Triumphalism
Name / Identity changes & nostalgia
National targets and waiting times
Friction with external partners
Friction with other parts of the hospital especially wards and management
Ambiguous Co-dependent Conflict
Identity
Helpful friends
Nostalgia for how things used to be
Getting an ambulance divert
Getting hospital beds
Fear of winter
Sense of expectation hanging in the air
Injustice
Derogatory manner to other partners
Lack of vision and strategy
Tired of everything
Feeling neglected
People wasting ED time
Disconnectedness of other partners from ED
Lack of engagement from external partners
Undesirable behaviour of external partners
Overcrowding in ED seen separately from overcrowding in rest of the hospital
Isolation Abuse
No one listening
Blame other hospitals
Senior management disconnect with reality
Used and abused

7 FINDINGS

The findings from this research revealed three overarching themes from the perspective of members of the ED staff that bridge the emotions ranging from a sense of prestige through to feelings of being stigmatised. These three themes are: a sense of injustice, an ambiguous identity and a desire for empowerment.

When the first order themes were ranked in valency order from +3 to -3, they revealed seven second order themes with a hierarchy of elements contributing to each of the overarching themes:

Isolation (Isolation > Abuse)

Identity (Ambiguous Co-dependency > Ambiguous Identity)

Empowerment (Autonomy > Expertise > Professionalism)

The three overarching themes and the first and second order themes that underpin them are the key elements that motivate staff in ED to achieve a sense of prestige while simultaneously identifying factors from which staff want to escape to avoid stigma. The reader will be taken through the three overarching themes with supporting evidence for each one and subsequently consider the implications across staff groups in the discussion where I will describe a model for ED professional staff identification when working in potentially stigmatised organisations. Starting with injustice the discussion will move through to ambiguous identity and end on empowerment.

7.1 Injustice and Isolation

The most powerful comments came from a member of staff summarising the sense of injustice and isolation. "A CQC inspector told us informally in ED that we weren't all that bad and that we did a lot of good stuff, but if they didn't rate us as *inadequate* – nothing would change". "The initial report was embargoed; the night before it was publicly released staff were in tears – we've tried so hard just to get kicked in the teeth again". These very personal, emotive and visceral comments capture the sense of confusing *Injustice* and of being singled out or isolated.

It was from *"Mama E.R."* that the overarching theme of *Isolation* emerged with elements of injustice and uncertainty being common features of the songs. At the start of the second half of the revue *"Mama E.R."* a seven-minute video was projected depicting an ED consultant seeking support and being turned away, rejected, outcast. This was supported by the backing track *"All by Myself"* by Eric Carmen, 1975, a melancholic power ballad. Contemporaneous notes indicated how 'pointed' and 'close to the bone' this video was and at seven minutes' long 'relentless and demonstrating frustration in all directions'.

The theme of *Isolation* was also supported by receptionists having to create a *"wall"* between patients and clinical staff to protect the department as well as coded language and use of abbreviations by department staff that are not commonly used by other parts of the hospital system. Examples include: *"lockdown", "black alert", "OPEL-4", "internal critical incident".* In early discussions with senior staff about how to approach the subject of staff identification and organisational stigma, I was told to be prepared to encounter *"fortress ED"* and that *"they will corral the wagons"*.

7.2 Ambiguous Identity

The next overarching theme of *Ambiguous co-dependent identity* emerged from second order themes of dependency and friction with external partners in the 0 to -1 valency zone. Reliance on others, nostalgia for the past, the overarching dread of winter and dependence on others to play their part while simultaneously being expected to cope on their own also contribute to the ambiguous identity.

The contested position of ED in the hospital and the local healthcare system as well as the different characteristics of staff – ED being unique compared to other specialties - (which can all claim uniqueness as well), while recognising that the ED is more connected to a range of specialties than other specialties are connected to each other, highlights the mixed functions and expectations of ED in the wider hospital context. Revue songs capturing the ambiguous identity included: *The ED Consultants' Song (to the tune of "I do, I do, I do")* listing the wide range of conditions, clinical presentations and expertise ED staff have to consider and treat, compared to *The Physicians [Medical Consultants'] Song What's the Fuss and the Rush? (to the tune of "The Name of the Game")* and *The Neurosurgeons' Song (to the tune of "Thank you for the Music").* The focus of conditions for the other specialties respectively is either wide, but with endless tests to be arranged at leisure or narrow, with urgent tests that have to be arranged immediately. For both specialties outside ED the expectation is that ED should do the tests and call back if positive, the ED view being *"you are the specialists – over to you"* and the retort typically being *"no, you are your own specialty; do as we advise or sort it out yourself!"*

Further support for the theme of contested identity and transient importance is reflected in *The Paramedics Song (to the tune of: Honey Honey)***,** where the *"Knights of the Road"* - 'the cavalry' in public perceptions offload their responsibilities once arriving at ED, their arrival and departure often heralded with flashing lights, sirens and whirring helicopter rotor blades. This is characterised by the spectators who turn their back on ED to watch the activity on the helipad.

Data from the 2017 and 2018 ED staff specific surveys also provide evidence of the ambiguous co-dependent identity of ED staff when assessing staff views regarding personal development (Q19b – Q20; Appendix 2, page 65). Dissatisfaction with the limited attention to career or role specific training beyond just hospital mandatory training (up to 82% dissatisfaction depending on staff role) indicated uncertainty in the higher or cross-cutting organisation structures about the requirements for ED staff and their careers. Examples include:

- Up to 60% of ED staff feeling appraisals did not help them to do their job
- Up to 49% of staff feeling they had no clear objectives
- Up to 54% of staff feeling their work was not valued by the organisation
- Up to 57% of staff feeling that the organisations values were not discussed with them in the context of ED work

7.3 Desire for Empowerment

The final overarching theme of *Empowerment* emerges from the higher valency first order themes ranging from +3 to +1 that could be grouped and ranked into the second order themes of Autonomy, Expertise and Professionalism. The data sources supporting the *Empowerment* theme emerged from the *Staff Listening Event* supported by the revue "*Mama E.R."*

From the listening event there was an overwhelming desire from ED staff to be able to change things, either to start initiatives or to end what staff considered to be poor value activities reflected in a 5:1 ratio of comments supporting change rather than remaining the same. The ability to structure their own delivery of services had suggestions ranging from avoiding duplication of form filling and computer entries to sourcing the most appropriate equipment for the needs of patients as well as providing appropriate training courses for staff, advisory services for patients and relatives and the opportunity for staff to promote what they considered to be *"success stories"* beyond the dry statistic of waiting times.

These examples underpin the second order theme of *Autonomy* as well as *Expertise* – having the knowledge and skills to assess the best thing for patients as well as *Professionalism* with a sense of responsibility to promote healthcare beyond the confines of the ED with advice that may influence patient choice and subsequent consumption of healthcare resources. The second order theme of *Expertise* was highlighted in the "*Mama E.R."* revue with several songs reporting the expertise of staff groups working in ED such as Porters, Radiographers, REACT (the Rapid Enablement And Care Team), Receptionists and ED Consultants.

Interestingly, although patient care was often listed as a top priority and could align to a theme of professionalism, overall comments about patient care were delivered in language that only just had a positive valency score of +1. From "*Mama E.R."* one song *The REACT Team Song (to the tune of: Chiquitita)* was strongly symbolic of healthcare ED staff expert knowledge and professionalism. The only *patient* centred song was highly negative in its tone with passive, subjective themes heavily detracting from positive themes outlined in the *Listening Event*. It may be fair to say that this one song *Drama Queen (to the tune of: Dancing Queen)* aimed at a particular patient group is not representative of how ED staff view patients overall.

Examples of evidence to support the first and second order themes that underpin the overarching themes of isolated injustice, ambiguous identity and empowerment have been outlined. In the discussion these concepts will be described further leading to the construction of a model of how ED professional staff navigate the process of identification when working in the mercurial world of an organisation with stigma.

8 DISCUSSION

The findings reveal three overarching themes of injustice, ambiguous identity and empowerment that influence ED staff understanding and identification within the organisation. Before exploring these further in the discussion, it is worth considering two broad or general findings from the study that both cut across and integrate all of the three themes, providing connections that may help the reader appreciate the results as a whole system and not just as three isolated elements.

The first broad theme of humour can inform us about beliefs and attitudes to the working environment. This is germane to the study since so much data emerged from the humorous revue "*Mama E.R."* The second broad theme relates to the issue of communication and more specifically the communication climate. This is important since the communication climate is an essential part of how stigma arises from those arbiters who apply labels, how stigma is perceived by the recipients and how individuals and organisations can choose to engage and influence the communication climate to avert or manage the consequences of stigma.

Following the discussion on humour and the communication climate, a model will be unveiled of how healthcare workers manage their identity when working within potentially stigmatised organisations - a referred to as the "*The Chosen Locus of Identification Model for Healthcare Professionals".* Finally the influence of stigma on the three elements of injustice, ambiguous identity and desire for empowerment will be discussed highlighting how for professionals, the process of identification considers those elements to permit the construction of a fluid, permeable and changeable identity. The discussion will build on the established literature to provide new insights into the understanding of organisational stigma and healthcare professionals identification.

8.1 The Role of Humour

Data from field participation and interviews do not constitute a mirror of reality, but rather compose one way of opening up a scene (Denzin, 1997). The opportunity to use the medium of humour was an alternative method for obtaining disclosure of the views of healthcare workers in the Emergency Department.

The use of humour to tell narratives about social values has a long history. From the fourth Century BC, Aristophanes and his fellow Greek playwrights were able to poke fun at contemporary life while providing an insight into Greek society, institutions and the lives and values of the audiences.

Humour provides a memorable vehicle through which employees learn, select, confirm, challenge and transform identity. "*Mama E.R."* was able to enhance the memorability of its message by "piggy-backing" the narratives on to very well-known tunes from the 70s and 80s

pop group ABBA. This familiarity with the music creates a bond with the audience that immediately becomes “on-message” with the storyline and can focus more on the content and context of the script, the rhyme and rhythm enhancing the ability of the audience to predict the next line of narrative, the accuracy of the audience prediction either being rewarded with affirmation of knowledge and understanding or the beneficial effects of laughter when presented with the unexpected. Jokes often connect seemingly unrelated issues together in unexpected ways. Humour can indicate ambiguity, contradiction and paradox (Hatch and Erhlich, 1993).

Humour may maintain organisational culture (Collinson, 2002; Meyer, 1997a; Seckman and Couch, 1989). Humour provides an opportunity to avoid certain topics strategically (Tracy, 2000). Humour reveals organisational beliefs and characters (Kahn, 1989). Narratives reflect and shape the interpretation of self and situations upon which members act (Eisenberg, 2001).

Humour, highlighting incongruity and lack of control makes the identity threat external rather than intrinsically connected to themselves. Humour can take attention away from the broader organisational policies and structures that create and maintain dysfunctional, absurd and stress-inducing situations (Tracy et al., 2006). Humour provides a dimension of social control since it highlights the deviance from accepted norms whilst not explicitly revealing the judges or specific determinants of those norms. Hence humour reinforces the dominant ideological position and provides a mechanism for scrutinising and highlighting activity. The use of humour may reveal a one-way power gradient e.g. the joker can make a judgement that induces self-reflection on the part of the recipient.

Superiority humour is cohesive and solidifies groups (Coser, 1959; Coser, 1960; Francis, 1994; Meyer, 1997b; Pogrebin and Poole, 1988). Self-derision is a special type of superiority humour (Lynch, 2002). Self-deprecating humour is a form of confession where individuals first admit and then seek redemption for perceived deviances from expected norms. This ensures a power hierarchy is perpetuated (Foucault, 1984).

Humour serves employee identity needs through differentiation, superiority, role distance and relief. Humour is often targeted to individuals outside the group. Employees and workers distance themselves from negative perceptions and bolster their esteem by use of reframing, recalibrating and refocusing techniques (Ashforth and Kreiner, 1999).

8.2 The Communication Climate: its role in Identity, Stigma Formation and Organisation Responses

"The process of negotiating one's identity within and in relation to the organisation, is one of the most fundamental 'flows' of communication that constitutes organisations" (Putnam and Nicotera, 2009).

The communication climate influences perceived external prestige. *Perceived external prestige* refers to the employees' personal beliefs about how other people outside the organisation judge its status and prestige. Employees holding a positive perceived external prestige "bask in the reflected glory" of the organisation and develop a higher level of cognitive organisational identification, integrating beliefs about one's organisation and one's identity (Dutton et al., 1994).

The communication climate of an organisation is more centrally linked to organisational identification than the content of the communication i.e. how you say it is more influential than what you say. This was summarised into five hypotheses by Smidts et.al (2001) when investigating the impact of employee communication and perceived external prestige on organisational identification; employees have stronger organisational identification when they have first a sense of greater perceived external prestige, second a sense that they receive adequate information about their organisation and third information about how their roles fit into the organisation. In addition the climate of communication can influence how strongly employees identify with the organisation and finally how the content of the information is received influences organisational identification and identity (Smidts et al., 2001).

Identity can be viewed as an element of organisational control and as a consequence of how power is distributed within and between organisations. Organisational control can be exerted through a cultural media with the use of carefully chosen language. Hence one talks about "leader" rather than "supervisor or manager" since it is more "positive and seductive" (Alvesson and Willmott, 2002). Organisational control can be achieved with employees positioning themselves within managerially constructed themes. Corporate values are promoted as a means of legitimating objective social control (Burris, 1989).

Organisational regulation of identity is precarious and contested. Identity work is a significant medium and outcome of organisational control. Identity regulation is a pervasive and increasingly intentional modality of organisational control. Stigmatisation is a mode of social control which works at symbolic and moral levels, regulating alternative identities and behaviours through the continuous reproduction of social values (Cusack et al., 2003).

According to stigma theory, the reaction of others in the social environment determines whether or not a stigma will be incorporated into an individual's self-concept (Jones, 1984). Individuals who are aware of their stigma may be treated differently from those who are unaware (Ragins, 2008). Awareness of stigma or the potential for stigma and the pervading communication climate can influence whether individuals or departments within organisations are prepared to make disclosures that in turn may reinforce or reduce the impact of stigma. The revue "Mama ER" provided a potential mechanism for admitting awareness of stigma, effectively a pastiche for a department "hanging its head" in shame.

Disclosure may reduce the stress associated with hiding a stigmatised identity. A positive consequence of disclosure is that individuals may view it as a way to influence their environment. Disclosure allows affiliation of similar and alike people, thus offering a support resource and can influence organisational culture and institutional change. A key source of support for the disclosure of stigmatised identity is the degree to which the environment provides institutional support for disclosure. Institutional support is embedded in the culture, climate, practices and policies of the organisation or community. Institutional support may take symbolic or instrumental forms. The revue *"Mama E.R."* represents a mode of institutional symbolic support.

Four relevant characteristics exist associated with the potential stigma that influence choices over disclosure: controllability, peril or threat, disruptiveness and the course or changes over time associated with stigma (Jones, 1984). Of these, the notion of controllability is one of the most important aspects of stigma (Crocker et al., 1998) since the individual or organisation may be seen as responsible for causing or maintaining the stigmatised condition. The organisation may also have control over the timing for release of information which may

influence the impact of disclosure. Considering the impact of stigma characteristics on disclosure may help one to understand why some organisations may choose to massage, fabricate or hide figures relating to performance to avoid stigma. There is conscious consideration to the risks and benefits associated with disclosure.

Social Identity Theory claims that people define themselves in terms of their social group memberships and strive to maintain a positive image of the 'ingroup' because a positive regard for the 'ingroup' can enhance members' self-view (Tajfel and Turner, 1986). There is a need for a positive social image when concerns about the negative connotations of one's social group membership is raised (Owuamalam and Zagefka, 2011). Challenges to one's social image can come from the negative behaviour of fellow group members or result from mere membership of a stigmatised group (Crocker et al., 1998). This study suggests that healthcare professionals can navigate events and choose identities selectively depending on the prevailing circumstances.

How an organisation is viewed externally can be a destabilizing force on *identity* requiring members to reconstruct and revisit their organisational sense of self (Tracey and Phillips, 2016). Professionals have options to distance themselves from undesirable labels or associations. People distance themselves from group membership that cannot contribute positively to their self-view (Snyder et al., 1986). It can be degrading for people to work in stigmatised or illegitimate organisations due to embarrassment, anger, loss of self-esteem for the workers (Sutton and Callahan, 1987), as well as challenges for their own identity and sense of meaning (Dutton et al., 1994). Non-profession healthcare workers may face the onslaught of stigma but have limited refuges for shelter. Identity distancing can occur when group boundaries are *permeable* (Ellemers et al., 1990) or the status hierarchy which places the

‘ingroup’ into an inferior position is unstable (Ellemers et al., 1999). Healthcare professionals have “permeability” since they can select identities, especially those that might be associated with higher moral ground.

Knowledge is not the same as understanding and this study explores beliefs and perceptions, the context of which may influence individual and collective understanding. The measurement of beliefs is key to capturing variation in professional identity. There is potential value in measuring beliefs along with belonging and attachment in research on professional identity (Barbour and Lammers, 2015). Through their professional bodies there may be more access to informed resources that allow healthcare professionals to contextualise the organisation and the labels attached to it. Those workers not within a profession are more isolated and potentially lack the commentary and perspectives provided by regulatory bodies or professional institutions. In relation to the data for this study, the communication climate also influences how people complete staff surveys and may have more influence on beliefs than tangible events.

8.3 A Model for Professional Identification Working in Stigmatised Organisations

Taking a 2-dimensional shape, imposing a twist and joining the ends together creates a Möbius band or loop. This has unusual properties of inseparable duality. It has a single surface, it is bounded by a single edge, yet it has structure existing in 3-dimensional space and it is unorientable. The Möbius loop concept will be used as the basis for the model of professional identification in a stigmatised organisation since it represents inseparable co-dependent entities existing in a complex relationship.

Figure A is a simple representation of a Möbius loop.

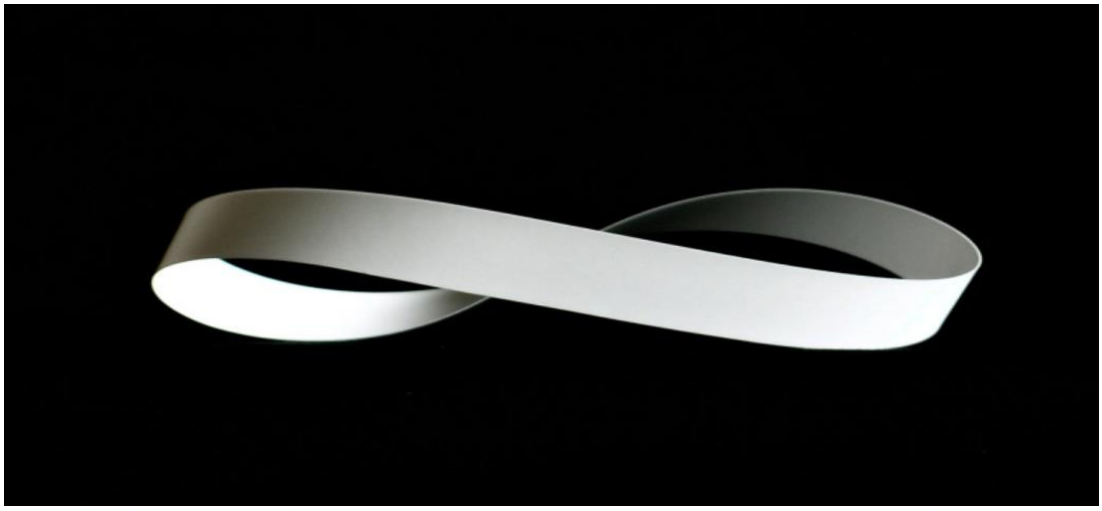


Figure A

It is along an axis of agency that healthcare professionals choose landmarks of institutional standards, ideology, professional affiliations and values to position themselves and identify selectively with elements of the healthcare environment to influence and navigate the challenges facing an organisation. This is represented further in Figure B showing healthcare professionals' identification choices in the context of negotiating the three overarching themes from this study of *injustice*, *identity* and *empowerment*.

Figure B

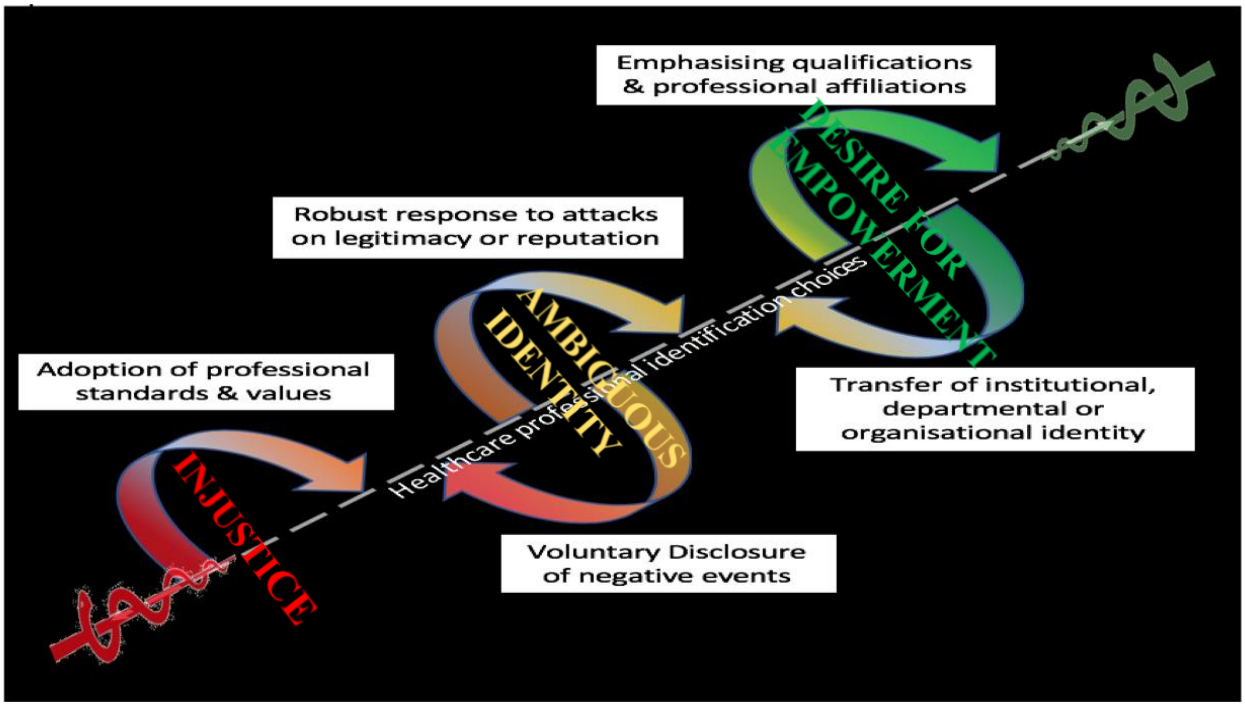


Figure B *The Chosen Locus of Identification Model for Healthcare Professionals*

8.4 Organisational Stigmatisation influences Healthcare Professionals' tactics for managing a sense of Injustice, Ambiguous Identity and Desire for Empowerment.

A single individual may start the process of stigmatisation. The status of the claim maker represents an important influence on the emergence of organisational stigma. Status confers benefits of greater attention, and visibility and increased resources and connections (Merton, 1968). The higher the status of the claim maker, the greater the likelihood that a critical mass of stakeholder group members will accept the label and claims made about the offending organisation, that a particular label will stick, and thus stigmatise the organisation.

Organisational stigma is greatest when directed towards an organisations' conduct *and* identity (Law, 2016).

Stigma is part of a spectrum of negative social evaluations. Social evaluations include concepts of reputation and legitimacy. In complex and ambiguous situations society relies on a selected set of arbiters to render and disseminate judgements (Hirsch, 1972; Zuckerman, 2000). Although when viewed in a negative context these evaluations do not necessarily equate to stigma, appreciating the central role of reputation creates a lens through which to view stigma. Reputation is seen as a critical non-purchasable asset (Dollinger et al., 1997). Reputation is reinforced by others who provide endorsements i.e. it is socially constructed. It is an output not an input and it is an outcome of *legitimacy* (Hudson and Okhuysen, 2014). Hence from the model, initial attention to professional standards and values form a foundation of legitimacy from which it is then easier to challenge robustly attacks on legitimacy. Once legitimacy is established or at least accepted, this position unlocks the valuable asset of a positive reputation.

Reputation acts as a substitute for detailed knowledge. An organisation may have several different reputations based on different attributes. In the non-profit sector peers are often used as judges to help make resource allocation decisions. Peer reputation is influenced by a number of factors and therefore there is a need to achieve high performance across a number of dimensions (Padanyi and Gainer, 2003). Peer reputation is a key strategic variable that should not be overlooked.

Positive organisational reputation increases stakeholders' expectations for positive outcomes. These expectations cause employees to identify more with the high reputation organisation.

Professionals generate a positive feedback loop by promoting legitimacy and reputational issues that construct elements of an organisation with which they can more easily identify.

High reputation organisations accrue a stock of social capital with stakeholders over time, prompting stakeholders to give the organisation the "benefit of the doubt" when negative events occur. However potentially more attention is paid to a negative event when associated with a high reputation organisation. A high reputation can elevate stakeholders' expectations about an organisation's future behaviour; in other words it "raises its own bar" and it amplifies the adverse effects of a negative event on stakeholders' perceptions and support toward an organisation. High reputation is a burden for an organisation with low stakeholder identification support. High reputation is a benefit when considering high identification stakeholder support (Zavyalova et al., 2016). High reputation provides advantages, better access to resources, high quality workforce and financial access. In other words, a high reputation paradoxically simultaneously sets a high bar or cuts an organisation a lot of slack depending on stakeholder identification.

Key arbiters typically have legitimate platforms to make assessments of individuals values and subdivide into social, legal and economic arbiters. This conforms to Socially Situated Judgement Theory (Bell and Tetlock, 1989; Kahneman, 2003; Tetlock, 2002). These arbiters or external stakeholders are susceptible to human biases. Dynamic social processes influence the stakeholders' assignment of stigma and reciprocal influences among and between arbiters enables stigma to diffuse across audiences and to extend its reach. Arbiters may simultaneously have overlapping or opposing interests. Stigma can be persistent because there is a broad range of outcomes. The power dynamics may determine how healthcare professionals can influence conflicting outcomes.

Arbiters seek to provide meaning that is compelling to their audiences (Fligstein, 1997). Arbiters motivation may be to consolidate their own position and enhance their own reputation. Healthcare professionals can assume the role of internal arbiters or stakeholders within their organisation. Multiple biases can enter into the process of making judgements. Biases may be cognitive, affective and attributional (Kahneman, 2003; Brigham et al., 1997; Meindl et al., 1985).

Stigmatisation of undesirable behaviour may help an organisation increase or enhance its social capital. It may set a standard of deviance to be avoided reinforcing "counter stigmatising" behaviours that are beneficial to the organisation's survival (Powell, 2001). It may seem paradoxical and counterintuitive, but for this reason healthcare organisations or individuals might actually promote stigma. Thus an internal echo of the stigmatisation process occurs when members within the stigmatised organisation choose to deflect blame and stigma on to specific individuals or areas of the organisation to protect themselves.

Stakeholder group members will cognitively dis-identify with a stigmatised organisation (Elsbach and Bhattacharya, 2001; Bhattacharya and Elsbach, 2002). Healthcare professionals may choose to stigmatise their own organisation rather than risk being associated with it if they perceive the risk of disclosure is in the interests of their personal professional or institutional identity. Regulatory statutes may indeed compel healthcare professionals to reveal potentially harming information about their own organisation. Coexisting with this activity, healthcare professionals may choose to transfer their identity between profession, institution, department or organisation.

Merrill (2011) explored the idea of reputation as a key resource contributor to a hospital's competitive advantage. The social and political standing of the CEO may be crucial to organisational resilience to potential stigmatising events. This may also explain why the CEO of an acute hospital is vulnerable to carrying the full responsibility for stigmatising events in order to protect the overall viability of the organisation's reputation and survival (Wiesenfeld et al., 2008). A CEO with a professional healthcare background will have an understanding of how members of the profession navigate and interpret information presented to them. However there potentially exists a dual identity crisis and risk of double jeopardy since the CEO may be informed of challenges to legitimacy and reputation from multiple sources without the luxury of taking refuge in the guise of professional institutional identity. Having healthcare professionals in clinical leadership structures within a hospital may provide a safety check and early warning system for CEOs to identify potentially threatening or stigmatising events.

Organisational reputation and visibility of the CEO are primary organisational assets in times of crisis. A defensive response to a crisis is as acceptable as an apologetic response if the CEO is visible in the response and the organisation's prior reputation is favourable. The best stakeholder attitudes to an organisation faced by a crisis emerge with the combination of a good prior reputation and a defensive crisis response and CEO visibility in the immediate response. "It is important for organisations to learn from previous mistakes, establish favourable relationships with stakeholders and most importantly develop a history of ethical behaviour, if they are to capitalise on the opportunities inherent in crisis situations" (Turk et al., 2012). The credibility of the CEO is positively associated with perceived organisational reputation (Men, 2012).

Kanter's numerical proportions hypothesis holds that groups in the numerical minority face performance pressures, stereotyping and isolation effects relating to their small numerical size and that these challenges lessen as the groups increase in size. As stigmatised groups become larger and more visible, power relationships may shift and perceptions of the stigma become less negative (Kanter, 1977). These processes may be amplified if the disclosure occurs among those in positions of power and authority in organisations. Organisations often choose their CEO from an elite cohort of individuals as a tactical asset in the case of potential future crises. For "elites" with high social capital, judgement may be less negative (Adler and Kwon, 2002). Mitigating examples of high social capital include "elite" individuals sitting on several influential boards, having influential friends and prestigious credentials. These network effects help to buffer elites with high social capital from stigma (Wiesenfeld et al., 2008).

CEO credibility also positively influences employee engagement by influencing how employees perceive the organisation's reputation. The individual employee's interactions within and external to the organisation can influence external prestige and self-esteem through identification (Smidts et al., 2001). The employee with the most power and influence is the CEO emphasising his or her role as a key strategic organisational asset. Beyond the choice of CEO an organisation can also "invest" ahead of an unknown-but likely to occur- stigmatising event through recruitment of individuals who share values and good co-worker relationships (Kulik et al., 2008). Again having healthcare professionals within management or leadership roles in the organisation can simultaneously increase their bonded identity while being deployed to soften the perception of events becoming stigmatising.

Understanding the institutional character of professional identity goes to the heart of what it means to be a professional. In healthcare professional identity is shaped by rapport with

patients and the work environment. Professional identity is characterised by group affiliations as well as roles that are defined in part by other roles and other professions. For example physician identity is influenced by nurse identity. Apker and Fox determined that nurses identified more with their occupation than their organisation. Supportive communication creates trust. Support from nurse managers predicted identification with the hospital but not the profession. High levels of autonomy, support by colleagues and traditional duties leads to increasing identification with the nursing profession. High levels of autonomy and support by managers improved identification with the hospital (Apker et al., 2003).

In 2017 and 2018 the sense of disconnection from the organisation varied by staff group potentially influenced by numerous changing factors altering individual perceptions of the organisation. Disconnection from Senior Managers in the organisation was a strong theme among clerical workers and HCAs, the exception being the very high level (54%) of Sisters and Charge Nurses feeling disconnected in 2017. An organisation that has lost the support of its Nurse Managers is vulnerable to an unravelling of support at lower levels of the organisation. 2017 was a year of extreme high risk for the index hospital having achieved the disapproval of so many of its senior nursing staff. This was the year of "financial special measures" when conversations focused on saving money dominated the organisation. Although employees care about the economic achievements of their organisations, they are even more concerned about social responsibility and value added by their organisations – which ultimately derive from core values.

"Identity and identification are terms that travel easily across levels of analysis. They simultaneously convey distinctiveness and oneness while allowing for blurring, multiplicity and dynamism" (Albert et al., 2000). Professional identity is distinctive among the sorts of

identity experienced at work because of its extra-organisational character. It is multi-level, involving the individual, the organisation and the institution. Healthcare professionals can take advantage of multiple extra-organisational identities to justify and maintain resilient intra-organisational activities. Professional identity implicates multiple levels of analysis. Identities are context bound. Interwoven identities are an entanglement of two persons: the core (personal) self and the trained (professional) identity. These may be impossible to separate representing two sides of the same 'coin'. Membership in seemingly incompatible categories may lead to loss of legitimacy (Zuckerman, 1999). Role theory suggests there could be person-role conflict which is "the conflict that may exist between the needs and values of a person and the demands of his set role". Role congruency across life domains reduces role conflict (Kahn et al., 1964).

Employees may be presented with multiple conflicting perceptions of their organisation and have to negotiate between conflicting tensions and loyalties. Employees can choose tactically how to navigate their role and understanding of the organisation (Bongiorno, 2017). Referring to individual, professional, institutional, organisational and societal standards may empower healthcare professionals with institutional affiliations and credentials to choose which path to navigate to suit their chosen identity. Hence healthcare professionals have the advantage of greater choice compared to those employees without professional recognition or representation.

Beyond doctors and nurses there are many other allied healthcare professionals (AHPs) with representative bodies. However a significant number of hospital employees such as Health Care Assistants (HCAs) have no such professional recognition or representative organisation. For these members of staff it may be much harder to navigate through contested organisational

roles and expectations to identify with the organisation. Vague job titles create ambiguity and confusion over professional identity. The possible loss of professional identity by those with established institutionalised identities is an impediment to the introduction of roles spanning health and social care. Attempts to prevent erosion of professional identity may disrupt the efforts of advocates for change, resulting in '*retaliatory'* challenges to the legitimacy and reputation of the professional worker or institution.

The struggle for identity is not just limited to individuals with ambiguous roles. There is a universal organisational need for recognisability (Czarniawska et al., 1997). Some organisations struggle to build positive perceptions among stakeholders because they belong to two or more categories that are deemed mutually exclusive. This may be of relevance to the index hospital that has to fulfil the role of local hospital as well as major trauma centre. So called 'hybrid identity organisations' find it easier to satisfy conflicting *legitimacy*, minimal standard requirements, than conflicting *reputation*, that requires elevated standards (Albert and Whetten, 1985; Pratt and Foreman, 2000; Whetten, 2006; Hsu, 2006). It is potentially harder for an organisation to rebuild reputation than to re-establish legitimacy (Mishina et al., 2012). This may be compounded by having to build reputation in multiple and potentially divergent directions with internal competition for resources.

The element of choice is an important part of constructing identity and identification. Organisational identification reduces the range of decisions as choices get confined to alternatives assessed to be affirming such identification (Tompkins and Cheney, 1985; Godfrey, 1998). Therefore the exercise of discretion in organisations is 'bounded'. The freedom or autonomy to make choices is a key element of *empowerment,* one of the

overarching themes to emerge from this study. Feelings of empowerment are affected by a variety of individual, interpersonal and positional variables (Koberg et al., 1999).

Empowerment is defined as a process of orienting and enabling individuals to think, behave and to act in an autonomous way. It helps workers to own their work and take responsibility for the results (Sahoo et al., 2010). Empowerment comprises individual cognitions and perceptions that constitute feelings of behavioural and psychological investment in work (Conger and Kanungo, 1988; Spreitzer, 1995; Spreitzer, 1996; Zimmerman, 1990). Dimensions of empowerment include: decision making, professional growth, status, self-efficacy, autonomy and impact. Of these six dimensions, three of them - professional growth, status and self-efficacy - are significant predictors of organisational and professional commitment (Bogler and Somech, 2004). Perceptions of empowerment increase with organisational rank, with leader approachability, group effectiveness and the worth, or equity, of the group (Koberg et al., 1999). Healthcare professionals utilising these associated factors have greater opportunity to become empowered either in reality, or to perceive themselves as empowered through the choices and affiliations available to them.

An objective of *empowerment* is a redistribution of *power* between management and employees (Greasley et al., 2004). *Social Cognitive Theory* (SCT) is a useful framework for analysing feelings of empowerment. SCT emphasises individual explanations, perceptions, and interpretations of work behaviour and attitudes within a particular work environment or context (Shetzer, 1993). SCT involves interaction of three entities; individual, behaviour and environment. This is concordant with the findings from this research in which individual and collective beliefs influence behaviours and responses to staff surveys that can change according to not just the physical environment but more importantly the political, managerial and

regulatory environment. The anonymous results of the National Staff Surveys with the specific focus on the Emergency Department responses of the index hospital combined with the anonymous results from the - "*drop-in"*- event broadly outlined the first and second order themes that provided the elements of the two overarching themes of ambiguous co-dependent identity and empowerment.

Voluntary or unpaid commitment to the organisation may suggest a degree of choice can be exercised. This aligns to the overarching theme of *Empowerment* with the element of *Autonomy*. In this study the clinical staff groups surveyed were inclusive of high social standing professionally affiliated and professionally regulated staff in leadership roles alongside staff with fewer healthcare qualifications and less associated accountability.

Employees are more *committed* when they are *empowered* through involvement programmes such as greater emphasis on collective bargaining, encouragement for suggestions, job redesigning and greater autonomy to teams (Sahoo et al., 2010). Absence of these factors leads to the sense of 'isolation and abuse' in turn diminishing opportunities for empowerment.

Other factors that facilitate effective empowerment within organisations include: an informal organisational structure; a flexible, participative and learning culture; a reward and recognition system; non-routine and challenging jobs; access to resources and funds; degrees of autonomy and selection of leader; and establishing the leader as a role model with demonstration of mutual trust (Yukl and Becker, 2006). For an organisation to be effectively empowered management must adopt high involvement practices where power, knowledge, information, and rewards are shared with employees in the lower levels of the organisational hierarchy (Bowen and Lawler III, 1995). In general the greater degree of satisfaction in the staff surveys

displayed by healthcare professionals compared to health care assistants and clerical workers reflects closer contact or access to information and organisational knowledge. It should also be noted that rewards may be both financial and non-financial.

In this research, workforce organisational motivation was uniformly high for paid work among all staff groups. This changes when motivation or commitment is measured by unpaid work. The nature of work as well as relative internal and external priorities are likely influencers of whether or not healthcare staff demonstrate additional commitment that is not remunerated. The difference indicates that pay is the most highly motivating factor to induce commitment particularly for those employees not affiliated to professional institutions or subject to regulatory governing bodies. However, beyond financial reward as a motivator, the content of work tasks may be the most important influence on organisational commitment. Commitment can reflect individual goals that do not necessarily serve those of the collective (Ashforth and Mael, 1989). The relationship to organisational commitment varies by occupation. Studies across professions can partial out profession-specific variation. (Barbour and Lammers, 2015). Role ambiguity and role overload reduce feelings of empowerment (Seibert et al., 2004).

Autonomy is a key element of definitions on professionalism (Bartol, 1979; Hall, 1968). Skills and qualifications that legitimise expertise and membership of professional institutions enhance status and influence and in turn empower staff to make choices. In this study, autonomy contributing to a desire for empowerment ranked higher than concepts of expertise or professionalism perhaps indicating it is the element of work that healthcare professional employees value the most.

8.5 Implications for Organisations

Organisations need to recognise that being stigmatised is a harrowing, traumatic and brutalising experience for employees. Managers and leaders within organisations need to support employees to become empowered and informed or alternatively risk having a workforce that feels isolated within an ambiguous and unjust environment. A further risk is that employees may adopt behaviours that work against the desired aims or interests of the organisation. Employees are more committed when they are empowered through involvement programmes with encouragement for suggestions, job redesigning, training, sharing of information and greater autonomy for teams (Gowen et al., 2006; Sahoo et al., 2010). The interplay between subgroup composition and organisational identification may influence the way individuals resolve dilemmas among self, subgroup and collective interests (Polzer, 2004). In order to strengthen employees' identification, a prestigious organisation should emphasise its victories, whereas an organisation with less visibility should employ strategies to improve internal relationships between members and focus more strongly on the organisation's "raison d'être" (Fisher and Wakefield, 1998). Organisations should focus on legitimacy since discussions on achieving legitimacy tend to be viewed positively (DiMaggio and Powell, 1983). Strong support for employees during organisational crises including stigmatising situations may achieve mutual benefits that assist in the removal of the label of stigma swiftly and effectively.

8.6 Limitations of the Study

This study has to be considered in the context of the time it was undertaken and the antecedent factors. The situational context is important in understanding identity, and identification aligns to *Structuration Theory* (Giddens, 1986) that states all social interaction is situated in time and

space. An assessment against a timeline of significant political, social and economic policies could supply more background detail. The study provides an in-depth assessment of one department in an organisation, but the findings may not necessarily be generalisable to other hospitals although they are likely to be most relevant to hospitals with a similar major trauma centre and local community structure and responsibilities. The study does not attempt to contextualise recovery efforts occurring within the hospital that may have moderated the views of the survey respondents. The data from the NHS National Staff Surveys and the revue are representative of attitudes at the time or in the relatively recent past but do not provide an indication of future outcomes. This is in part balanced by the ED *"listening event"* where staff indicated an enthusiasm for change. The APOSIE score with an associated valency may be challenged since it imposes a label and could be considered a source of discrimination or bias to the study. The valency attached to the 'tone' of the contributions could be reassigned to a different polarity. For example, a desire for "autonomy" that allocated here as positive could be interpreted as "self-interest" with a more negative overtone.

8.7 Potential Implications and Areas for Future Research

Further research to validate the APOSIE technique may be the focus for another study. There may be value in understanding if it is applicable to other situations that require an assessment of beliefs and perceptions when modes of communication and easy access to "facts" within an organisation are limited. Analysing the detail from the 2017 and 2018 ED specific staff surveys will be repeatable in 2020 when the 2019 data becomes available. This will provide further information on the changing nature of identification, motivation and evidence of empowerment in the index hospital.

9 CONCLUSIONS

Identification and analysis of healthcare workers is complex and multifaceted involving an interplay of legitimising and reputational stakeholders in addition to individual and collective actions and beliefs. This is compounded by ambiguous identities, necessary although not always desirable co-dependencies and perceptions formed from incomplete knowledge and therefore subjective rather than objective beliefs. Uncertainty and sensing injustice also influence the attitudes and behaviours of staff.

Organisational stigma is distressing to staff. Healthcare professionals can navigate through stigmatising events using resources not available to non-professional staff groups. A range of strategies including swift, clear and transparent communication, recognising the expertise of staff and devolving decision making to promote autonomy facilitates staff identification with the organisation. Despite the notion of altruism being an element of healthcare workers' identity, there was no evidence from this study to support that concept. Professional status, pay, influence and negotiating power are elements that induce organisational commitment in senior clinical professional staff. For staff on lower incomes without professional affiliation or regulating bodies, pay remains the single significant factor influencing motivation for enhanced organisational commitment and identification.

10 APPENDICES

APPENDIX 1

2014 staff self-categorising as Emergency Care Practitioners (ECPs)

Type of Healthcare Trust	Numbers identifying as ECPs
Ambulance Trust	237
Mental Health Trust	9
Community Trust	7
Acute Hospital Trust with an ED	17
Index Trust	0

The 2014 National Staff Survey also calculated a *motivation score* for individual Trusts as well as for healthcare professional category but this was not analysed by department.

Healthcare Sector or organisation	Mean Motivation score (Min 1, Max 5)
Emergency care practitioners overall	3.5
Ambulance Trusts	3.12
Acute Trusts with an ED	3.78
Mental Health Trusts*	-
Community Trusts*	-
Index Trust emergency care practitioners*	-
Index Trust overall	3.59

*Insufficient responses to calculate a mean motivation score

2017 staff self-categorising as Emergency Care Practitioners (ECPs)

Type of Healthcare Trust	Numbers identifying as ECPs
Ambulance Trust	290
Mental Health Trust	19
Community Trust	14
Acute Hospital Trust with an ED	39
Index Trust	0

The 2017 National Staff Survey also calculated a *motivation score* for individual Trusts as well as for healthcare professional category but again this was not analysed by department.

Healthcare Sector or organisation	Mean Motivation score (Min 1, Max 5)
Emergency care practitioners overall	3.79
Ambulance Trusts	3.39
Acute Trusts with an ED	4.01
Mental Health Trusts	3.66
Community Trusts*	-
Index Trust emergency care practitioners*	-
Index Trust overall	3.83

*Insufficient responses to calculate a mean motivation score

APPENDIX 2

1 Views on the Organisation:

Q21a	Staff Group	2017 %	2018 %
Staff that don't think care of patients is the organisation's top priority	Clerical	15	7
	Consultants	25	10
	Health Care Assistants	8	17
	Sisters and Charge Nurses	21	0
	Staff Nurses	7	18

Q21b	Staff Group	2017 %	2018 %
Staff that don't think the organisation acts on patients concerns	Clerical	15	14
	Consultants	8	0
	Health Care Assistants	8	17
	Sisters and Charge Nurses	14	0
	Staff Nurses	3	6

Q21c	Staff Group	2017 %	2018 %
Staff who would not recommend it as a place to work	Clerical	23	14
	Consultants	8	0
	Health Care Assistants	0	17
	Sisters and Charge Nurses	29	0
	Staff Nurses	10	6

Q21d	Staff Group	2017 %	2018 %
Staff who would not recommend a friend or family member for treatment at the organisation	Clerical	15	8
	Consultants	4	5
	Health Care Assistants	0	17
	Sisters and Charge Nurses	14	0
	Staff Nurses	7	12

Q22a	Staff Group	2017 %	2018 %
Staff who don't think feedback experiences of patients are collected	Clerical	18	14
	Consultants	0	0
	Health Care Assistants	0	22
	Sisters and Charge Nurses	0	0
	Staff Nurses	9	17

Q22b	Staff Group	2017 %	2018 %
Staff who don't think that they get regular feedback from the organisation	Clerical	33	33
	Consultants	4	15
	Health Care Assistants	25	0
	Sisters and Charge Nurses	54	0
	Staff Nurses	6	8

Q22c	Staff Group	2017 %	2018 %
Staff who don't think patient feedback is used for informed decisions in the department	Clerical	29	33
	Consultants	5	11
	Health Care Assistants	25	17
	Sisters and Charge Nurses	33	9
	Staff Nurses	5	0

2 Work Commitment

Q9d	Staff Group	2017 %	2018 %
Staff continuing to come to work despite feeling unwell (viewed as a bad thing to do)	Clerical	85	67
	Consultants	42	45
	Health Care Assistants	75	83
	Sisters and Charge Nurses	69	54
	Staff Nurses	66	54

Q9g	Staff Group	2017 %	2018 %
Staff who have put themselves under pressure to come to work (viewed as a bad thing to do)	Clerical	91	90
	Consultants	90	100
	Health Care Assistants	89	90
	Sisters and Charge Nurses	100	100
	Staff Nurses	93	95

Q10b	Staff Group	2017 %	2018 %
Staff working additional **paid** hours above their contracted hours	Clerical	38	27
	Consultants	54	45
	Health Care Assistants	33	50
	Sisters and Charge Nurses	25	23
	Staff Nurses	32	31

Q10c	Staff Group	2017 %	2018 %
Staff working additional **unpaid** hours above their contracted hours	Clerical	15	36
	Consultants	100	100
	Health Care Assistants	27	17
	Sisters and Charge Nurses	86	85
	Staff Nurses	63	48

3 Feelings regarding personal development

Q19b	Year	2017	2018
Staff who felt appraisal didn't help them do their job	Range %	16-60	28-54
	Dominant Staff Group	Clerical	Sisters

Q19c	Year	2017	2018
Staff who felt they had no clear objectives	Range %	0-49	9-38
	Dominant Staff Group	Clerical	Sisters

Q19d	Year	2017	2018
Staff who felt their work was not valued by the organisation	Range %	13-39	14-54
	Dominant Staff Group	Consultants	Sisters

Q19e	Year	2017	2018
Staff who didn't feel organisation values were discussed	Range %	0-57	21-43
	Dominant Staff Group	Consultants	Consultants

Q19f	Year	2017	2018
Staff who didn't feel their training needs were addressed	Range %	25-100	25-73
	Dominant Staff Group	HCAs	HCAs
		Clerical	Clerical

Q19g	Year	2017	2018
Staff who did not feel management supported training	Range %	0-11	0-50
	Dominant Staff Group	Sisters	Clerical

Q20	Year	2017	2018
Staff who had not had training beyond mandatory training	Range %	3-82	0-79
	Dominant Staff Group	Clerical	Clerical

4 Relationship with managers

Q9b	Year	2017	2018
Staff considering communication with managers was poor	Range %	14-54	8-46
	Dominant Staff Group	Clerical	Clerical

Q9c	Year	2017	2018
Belief management didn't involve staff in decisions	Range %	14-54	17-60
	Dominant Staff Group	Clerical	Clerical

9d	Year	2017	2018
Senior management not acting on staff feedback	Range %	14-46	11-53
	Dominant Staff Group	Clerical	Clerical

Appendix 3

An example of a full script libretto with externally directed triumphalist humour:

AMU/XXI (To the tune of 'Waterloo')

You lied, you said that you were full but you were empty,
Oh yeah, but we have got a divert and soon we'll be going home
So now you are gonna get hit
And soon you'll be deep in the shit

XXI, you were defeated we won the war
XXI, we're gonna stuff you for evermore
XXI, couldn't escape if you wanted to
XXI, all of the patients will come to you
Whoa whoa whoa whoa
XXI, finally getting what's due to you

My my, you thought that you were smart, that you were clever
Oh yeah, but we've been given beds and soon we'll all be in the clear
So how could you ever refuse
I think that we win and you lose

AMU, you were defeated we won the war
AMU, we're gonna stuff you for evermore
AMU, couldn't escape if you wanted to
AMU, all of the patients will come to you
Whoa whoa whoa whoa
AMU, finally getting what's due to you
So how could you ever refuse
I think that we win and you lose

(XXI are the redacted initials of a rival hospital)

An example of a full libretto with externally directed ridicule:

Neurosurgeons: (To the tune of "Thank You for the Music")

You're nothing special
In fact, you are being a knob
You'd think seeing patients
Was actually part of your job
But trying to get you to come to ED
Is harder than anything really should be
I'm so fed up of this
Can you just stop taking the piss?

God help us
Bloody neurosurgeons
It seems they've got the
Social skills
Of Gordon Ramsey
Totally unable
To speak nicely on the phone
Without a moan
Without a whinge, a whine or a groan
Try saying
Thank you, as a starter
And then we'll practice please

I've got a patient with back pain who barely can walk
D'you think that you might
Actually come down and talk
Direct to the patient
D'you think that you can?
Speaking in language
That they understand
Why not give it a try?
And stop bleating about
MRI

Repeat chorus

If, we are lucky
One day they just, might all, grow up
Into the Neurosurgical Consultants
That we love
God knows how
They do that

An example of a full libretto promoting internally directed experienced competency:

Emergency Department Receptionists (To the tune of "Voulez Vous")

People everywhere
A sense of expectation hanging in the air,
Giving me a stare,
Across the room as if they think I really care,
And here we go again, we know the start, we know the end
Masters of the screen
We've seen it all before and now we're back to get some more,
You know what I mean

Who are you (ah ha)
What's your date of birth (ah ha)
What is your address (ah ha)
Do you have to bother me
Who are you (ah ha)
What is your problem (ah ha)
And you did it when (ah ha)
Have you seen your own GP
Who are you...

Go and take a chair
The Triage Nurse will see you somewhere over there
No I don't know when
You'll get to see a Doctor, it can all depend
The queue is getting worse, its growing more, the waiting time
Is 4 to 5 hours
We've seen it all before and now we're back to get some more,
We hold the power

Who are you (ah ha)
What's your date of birth (ah ha)
What is your address (ah ha)
No you're not about to die
Who are you (ah ha)
What is your problem (ah ha)
And you did it when (ah ha)
Have you tried the XXI
Who are you...

Appendix 4a Initial coded 1st & 2nd order themes and overarching theme

1st Order theme	APOSIE	Colour code	Sum score	1st Order Valency	2nd Order themes	2nd Order numerical	Overarching theme
Treating patients comprehensively in ED	AOI	😀😀😀	😀😀😀	3	Professionalism	1	
Promote and publicise clinical outcomes	AOIE	😀😀😀😡	😀😀	2	Professionalism	1	
Clinical outcomes and patient care are priorities	AOSI	😀😀😡😀	😀😀	2	Professionalism	1	
Professional expertise in ED	AOSI	😀😀😡😀	😀😀	2	Professionalism	1	
Top priority on patient care	ASI	😀😡😀	😀	1	Professionalism	1	
Issues with staffing numbers	APOIE	😀😡😀😀😡	😀	1	Professionalism	1	
Issues with training for staff	APOIE	😀😡😀😀😡	😀	1	Professionalism	1	
Helpful friends	POSIE	😡😀😡😀😡	😡	-1	Professionalism	1	EMPOWERMENT
Staff having ideas	AOI	😀😀😀	😀😀😀	3	Expertise	2	
Knowing the right questions to ask	AOSI	😀😀😡😀	😀😀	2	Expertise	2	Valued & Trusted Skills
Significant knowledge about other people's roles	AOSIE	😀😀😡😀😡	😀	1	Expertise	2	
Praise for colleagues and ED leadership	AOI	😀😀😀	😀😀😀	3	Autonomy	3	
Staff have ideas for change	AOI	😀😀😀	😀😀😀	3	Autonomy	3	
Staff keen for changes	AOIE	😀😀😀😡	😀😀	2	Autonomy	3	
Normalisation of practice to cope with pressures	APOI	😀😡😀😀	😀😀	2	Autonomy	3	
Triumphalism	ASI	😀😡😀	😀	1	Bonding / Branding	4	
Name / Identity changes & nostalgia	APOIE	😀😡😀😀😡	😀	1	Bonding / Branding	4	
Nostalgia for how things used to be	POSIE	😡😀😡😀😡	😡	-1	Bonding / Branding	4	
Derogatory manner to other partners	APSE	😀😡😡😡	😡😡	-2	Bonding / Branding	4	IDENTITY
Envy of some external elements	PSE	😡😡😡	😡😡😡	-3	Bonding / Branding	4	
Friction with external partners	APOSIE	😀😡😀😡😀😡	🐸	0	Friction with externals	5	Contested or Ambiguous
Friction with other parts of the hospital especiallty wards and management	APOSIE	😀😡😀😡😀😡	🐸	0	Friction with externals	5	
Getting an ambulance divert	POE	😡😀😡	😡	-1	Reliance on others	6	
Getting hospital beds	POE	😡😀😡	😡	-1	Reliance on others	6	
Fear of winter	POSIE	😡😀😡😀😡	😡	-1	Uncertaincy	7	
Sense of expectation hanging in the air	PSI	😡😡😀	😡	-1	Uncertaincy	7	
Lack of vision and strategy	PSIE	😡😡😀😡	😡😡	-2	Uncertaincy	7	
Tired of everything	PS	😡😡	😡😡	-2	Despair	8	
Feeling neglected	PSIE	😡😡😀😡	😡😡	-2	Despair	8	
No one listening	PSE	😡😡😡	😡😡😡	-3	Despair	8	ISOLATION
National targets and waiting times	APOIE	😀😡😀😀😡	😀	1	Being done to	9	
People wasting ED time	POSE	😡😀😡😡	😡😡	-2	Being done to	9	Cognitive or affective
Blame other hospitals	PSE	😡😡😡	😡😡😡	-3	Being done to	9	
Senior management disconnect with reality	PSE	😡😡😡	😡😡😡	-3	Being done to	9	
Used and abused	PSE	😡😡😡	😡😡😡	-3	Being done to	9	
Disconnectedness of other partners from ED	POSE	😡😀😡😡	😡😡	-2	Treated differently	10	
Lack of engagement from external professional partners	POSE	😡😀😡😡	😡😡	-2	Treated differently	10	
Undesirable behaviour of external partners	POSE	😡😀😡😡	😡😡	-2	Treated differently	10	
Overcrowding in ED seen separately from overcrowding in rest of the hospital	PSIE	😡😡😀😡	😡😡	-2	Treated differently	10	

Appendix 4b Final overarching themes coded by 1st & 2nd orders ranked by APOSIE valency

1st Order theme	1st Order Valency	New 2nd Order themes by Valency	New 2nd order numerical	Old 2nd Order themes		New Overarching themes
Treating patients comprehensively in ED	3	Autonomy	1	Professionalism		
Staff having ideas	3	Autonomy	1	Professionalism		
Praise for colleagues and ED leadership	3	Autonomy	1	Professionalism		
Staff have ideas for change	3	Autonomy	1	Professionalism		
Promote and publicise clinical outcomes	2	Expertise	2	Professionalism		
Clinical outcomes and patient care are priorities	2	Expertise	2	Professionalism		Empowered Autonomous Professional Expertise
Professional expertise in ED	2	Expertise	2	Professionalism		
Knowing the right questions to ask	2	Expertise	2	Professionalism		
Staff keen for changes	2	Expertise	2	Expertise		
Normalisation of practice to cope with pressures	2	Expertise	2	Expertise		
Top priority on patient care	1	Professionalism	3	Expertise		
Issues with staffing numbers	1	Professionalism	3	Autonomy		
Issues with training for staff	1	Professionalism	3	Autonomy		
Significant knowledge about other people's roles	1	Professionalism	3	Autonomy		
Triumphalism	1	Professionalism	3	Autonomy		
Name / Identity changes & nostalgia	1	Professionalism	3	Bonding / Branding		
National targets and waiting times	1	Professionalism	3	Bonding / Branding		Ambiguity Co-dependency Identity
Friction with external partners	0	Friction with Externals	4	Bonding / Branding		
Friction with other parts of the hospital especialty wards and management	0	Friction with Externals	4	Bonding / Branding		
Helpful friends	-1	Dependency	5	Bonding / Branding		
Nostalgia for how things used to be	-1	Dependency	5	Friction with externals		
Getting an ambulance divert	-1	Dependency	5	Friction with externals		
Getting hospital beds	-1	Dependency	5	Reliance on others		
Fear of winter	-1	Dependency	5	Reliance on others		
Sense of expectation hanging in the air	-1	Dependency	5	Uncertainty		
Derogatory manner to other partners	-2	Injustice	6	Uncertainty		
Lack of vision and strategy	-2	Isolation	6	Uncertainty		
Tired of everything	-2	Injustice	6	Despair		Isolation Injustice Uncertainty
Feeling neglected	-2	Isolation	6	Despair		
People wasting ED time	-2	Injustice	6	Despair		
Disconnectedness of other partners from ED	-2	Isolation	6	Being done to		
Lack of engagement from external professional partners	-2	Isolation	6	Being done to		
Undesirable behaviour of external partners	-2	Injustice	6	Being done to		
Overcrowding in ED seen separately from overcrowding in rest of the hospital	-2	Injustice	6	Being done to		
Envy of some external elements	-3	Injustice	7	Being done to		
No one listening	-3	Isolation	6=	Treated differently		
Blame other hospitals	-3	Injustice	6=	Treated differently		
Senior management disconnect with reality	-3	Isolation	6=	Treated differently		
Used and abused	-3	Injustice	6=	Treated differently		

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